

Conduct Disorder: A Handbook for Elementary School Educators

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## **Abstract**

This research project examined the behavioural, social, and emotional issues affecting children and youth with conduct disorder. Based on the literature review, the deconstruction of theoretical and empirical studies, and findings from the needs assessment, *Conduct Disorder: A Handbook for Elementary School Educators* was created. This handbook was developed based on the evidence that conduct problems can most effectively be improved when multiple systems are included in the prevention and intervention of the disorder. Educators, related service providers, and the child all play an important role in designing and implementing effective interventions. Therefore, it is imperative to provide educators with the information necessary to begin this emerging collaborative process. The handbook was created as a tool for educators intending to enhance their knowledge when working with students with conduct disorder. A Needs Assessment was conducted to determine what educators wanted the handbook to contain to assist them in working with students displaying conduct problems. The educators evaluated the handbook, providing constructive feedback and confirming the potential value and practicality of this handbook for elementary school educators. The educators reported an increase in their understanding of conduct disorder, as well as a heightened awareness of the causal factors that contribute to the disorder. The list of community resources and agencies was thought to be a good starting point for educators looking for supplementary aids. The educators indicated that the handbook is a good reference tool to use when teaching students with conduct problems. The educators concluded with the hope that this handbook will be shared with others.

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## **CHAPTER ONE: THE PROBLEM**

In 2012, the Municipal Performance Measurement Program (MPMP), a performance measurement and reporting system, reported that the total crime rate per 1,000 persons in the Niagara region was 44.74. This measurement included all Criminal Code offences, excluding traffic, and has declined significantly since 2008, when the total crime rate was 55.96. The total youth crime rate per 1,000 youths in the Niagara region has also declined from 53.96 in 2008 to 15.21 in 2012 (Municipal Performance Measurement Program, 2012). The MPMP (2012) report states that crime rates can be influenced by economic, social, demographic, and political factors, as well as reporting policies and practices. Interestingly, as crime rates decline, graduation rates in Ontario have increased. Statistics Canada reports in 2007-08, 77% of students graduated with a high school diploma. The province saw a steady improvement in the number of high school graduates and in 2011-12, 83% of students graduated with a high school diploma. The Ontario Ministry of Education contributes the results to an increase in support from education and Student Success programs.

A relationship exists between antisocial behaviour and academic success. Hodgins et al.'s (2013) study attempted to identify behaviours in childhood that could be rated by classroom teachers and were associated with future criminality to inform childhood interventions. It was hypothesized that teacher ratings of students at age six and ten would capture antecedents of criminal offending in females and males up to age 24. Teachers assessed conduct problems (i.e. Fighting, hitting, disobedience, truancy, vandalism, and theft) and hurtful uncaring behaviours (i.e. Lying, bullying, blaming others, lack of consideration for others, failure to show sympathy, and failure to comfort peers) in 3016

males and females (Hodgins et al., 2013). Hodgins et al. (2013) found that teacher ratings of students' behaviours were associated with criminal convictions. More specifically, boys and girls with high scores for conduct problems and hurtful uncaring behaviour at age six were four-times more likely to be convicted for nonviolent crimes, and boys were five-times more likely to be convicted for a violent crime. At age ten, boys and girls with high scores for hurtful uncaring behaviour without conduct problems were associated with an increased risk for nonviolent and violent criminal convictions (Hodgins et al., 2013). The results from Hodgins et al.'s (2013) study highlights a need for the early identification and intervention of conduct problems in childhood and adolescences.

### **Background to the Problem**

*Conduct Disorder* (CD) is the most severe type of disruptive behaviour disorders and is one of the most common psychiatric disorders in childhood and adolescence (Ercan, Basay, Basay, Durak, & Ozbaran, 2011; Kauffman & Landrum, 2013). Approximately 6% to 16% of boys and 2% to 9% of girls under the age of 18 are diagnosed with CD (Kauffman & Landrum, 2013). A child or youth who is diagnosed with CD shows a persistent pattern of antisocial behaviour that significantly impairs their everyday functioning at home or at school or leads other people to conclude that the child is unmanageable (Kauffman & Landrum, 2013). The symptom categories include: physical aggression or threats of harm to people or animals; destruction of property; acts of deceitfulness or theft; and serious violations of age-appropriate rules (Ercan et al., 2011). There are two broad forms of conduct disorder. Overt aggression or undersocialized CD is characterized by acting out toward others verbally and physically (Kauffman & Landrum, 2013). Covert aggression or socialized CD is more difficult to observe and assess and is



characterized by antisocial behaviour (Kauffman & Landrum, 2013). Children can be “versatile” and show both overt and covert forms of CD. Compared to children who only engage in one type of antisocial behaviour, children who are versatile generally have more severe problems and their prognosis is worse (Kauffman & Landrum, 2013).

The causal factors that contribute to the development of overt and covert forms of antisocial behaviour appear to be the same. For boys and girls, the risk of aggressive behaviour is increased by a variety of personal, family, peer, and school-related factors (Kauffman & Landrum, 2013). Many children exhibit difficult, irritable temperaments. They are likely to develop low self-esteem and depressed affect leading to problems with peers and academic achievement (Kauffman & Landrum, 2013). These children are often rejected by their peers in childhood and gravitate toward a deviant peer group. The typical school experience of students with CD is highly negative and lends to further maladjustment. At school, they often experience highly punitive discipline and the attention given to their nonaggressive, positive behaviours are limited (Kauffman & Landrum, 2013).

### **Statement of the Problem**

The most common approaches to intervention for CD include parent management training, problem-solving training, family therapy, and treatments that address the individual and multiple social systems (Kauffman & Landrum, 2013). However, with a focus on early intervention, there is a lack of research focused on interventions for children with CD in mainstream classrooms. Recognizing the large prevalence of CD and its adverse outcomes, the considerable stability of the diagnosis overtime, and the risk of escalating aggressive and antisocial behaviour in untreated patients, it is important for

educators to be able to predict antisocial behaviour in order to be able to prevent it (Ercan et al., 2011). Further, educators should be equipped with strategies and interventions that they feel confident to use to address the academic and behavioural concerns for children and adolescents diagnosed with CD.

### **Purpose of the Study**

Educators need to be equipped with strategies that they can employ with reasonable effectiveness and immediacy because it is likely that at least one of their students will be highly disruptive, destructive, or assaultive toward other students or the teacher (Kauffman & Landrum, 2013). These behaviours are often accompanied by academic failure. When children exhibit aggressive antisocial behaviour and academic failure in the early years, the prognosis is grim, unless effective early intervention is provided. (Kauffman & Landrum, 2013). Lovejoy (1996) wanted to understand how adults interpret inattentive/overactive and aggressive behaviours and focused on teachers' reactions to inattentive/overactive and aggressive child behaviours in the school setting. Factors influencing attribution formation and discipline were also considered.

The sample consisted of 227 students at a Midwestern university and was divided into two groups (Lovejoy, 1996). The first group included 69 students in undergraduate teacher-training programs with practicum or student-teaching experience. The second group included 43 students with graduate-level training in education with a minimum of one year of professional teaching experience (Lovejoy, 1996). Lovejoy (1996) wrote four vignettes that described an eight-year-old boy in a classroom environment and manipulated the type of behaviour problem and diagnosis in each of the vignettes. A questionnaire was developed to assess the causal attributions for the child's behaviour, variables that may

affect the formulation of those attributions, and the participant's affective and disciplinary reactions to the child's behaviour.

Lovejoy (1996) found that social inferences are different for inattentive/overactive behaviour and aggressive behaviour in children. Overall, the participants believed that problem behaviour was associated with internal causes and could be controlled by the child. This finding remained consistent even when teachers were provided with information about external life events that might explain the behaviour (Lovejoy, 1996). Since teachers' attributions are related to their affective and disciplinary reactions to student behaviour, Lovejoy (1996) warns that teacher beliefs about children's motivations, intentions, and control over their behaviour needs to be considered when designing and implementing school-based interventions.

Moreover, when compared to the inattentive/overactive child, teachers were less likely to respond to aggressive children with helping strategies (Lovejoy, 1996). Instead, aggressive children are more likely to be reminded about the consequences of their behaviour for others and receive longer time-out periods. Teachers reported a greater acceptability of punishment for aggressive behaviour too (Lovejoy, 1996). Lovejoy (1996) explains the differential teacher responses to inattentive/overactive behaviour and aggressive behaviour as being mediated by the teachers' social inferences about the child's responsibility for the behaviour. Even though diagnostic status did not significantly affect teachers' reactions to child behaviour, perceptions of deviance did. In the second group, diagnostic status influenced beliefs about the appropriateness of ignoring child misbehaviour (Lovejoy, 1996). For example, if a child was diagnosed, the teacher believed it was less appropriate to ignore the misbehaviour. Therefore, Lovejoy (1996) suggests that

teachers might be quicker to intervene with children who have been diagnosed.

Similar to Lovejoy (1996), Thijs and Koomen (2009) were interested in examining how teachers' reports of their relationships with different types of kindergarten children (socially inhibited, hyperactive, and average) are related to their personal assessments of the severity and the causes of these children's behaviours. Thijs and Koomen (2009) examined three main hypotheses. First, it was anticipated that teachers would rate their relationships with socially inhibited and hyperactive children as relatively unfavourable. Second, Thijs and Koomen (2009) hypothesized that these relationship differences would be mediated by teachers' appraisals of children's behaviours. Lastly, it was expected that teachers' relationship perceptions, as subjectively biased representations, would be particularly unfavourable toward children whose negatively appraised behaviours were attributed to controllable factors.

The sample consisted of 81 teachers in relation to 237 children from regular kindergarten classes. Thijs and Koomen (2009) questioned teachers in the spring to ensure that relationships had sufficiently developed. The majority of the children had at least 1 year of experience in kindergarten, and knew their teachers for more than 6 months.

Teachers completed two different questionnaires (Thijs & Koomen, 2009). A modified version of the *Behaviour Questionnaire for 2- 6-year Olds (BQTSYO-M)* was completed for 1512 children, the total group of pupils from which the children were selected. The *BQTSYO-M* is a short screening instrument containing subscales for social inhibition and hyperactivity, and broadband scales for internalizing and externalizing behaviours (Thijs & Koomen, 2009). Next, teachers' appraisals of children's social behaviour were assessed with six items that were developed based on Rutter's (1975)

criteria for determining the seriousness of problem behaviour. Thijs and Koomen (2009) assessed teachers' casual attributions for children's social behaviours using three items adapted from Hastings and Rubin (1999). Teachers were given three questions representing attribution dimensions of locus, stability, and control, and selected a position on a continuous line from 1 to 10 for each question. Lastly, teachers' reports of their relationship with each of the children were assessed with preliminary and abbreviated versions of the *Closeness, Dependency, and Conflict subscales* from the authorized Dutch adaptation of the *Student-Teacher Relationship Scale* (Thijs & Koomen, 2009).

In support of the first hypothesis, when compared to the average children, Thijs and Koomen (2009) found that teachers reported less close and more dependable relationships for the inhibited and hyperactive children and more conflicted relationships for hyperactive children. Furthermore, teachers perceived more personal behaviour problems for the inhibited and hyperactive children versus the average children. Thijs and Koomen (2009) suggest that these perceptions partly explained the differences in relationship quality reported for the three types of children. It also appeared that perceived personal problems suppressed a negative difference in conflict for the inhibited versus the average children.

The third hypothesis, pertaining to the interaction between teachers' attributions of control and their perceptions of children's behaviour problems, was not supported with respect to dependency or conflict (Thijs & Koomen, 2009). However, it was supported in the case of closeness, both when perceptions of personal problems and when perceptions of social problems were involved. When teachers indicated that children had relatively little control over their social behaviours, the negative impact of perceived personal problems on closeness was relatively small (Thijs & Koomen, 2009). Yet, when teachers perceived

children to be in control of their own behaviours, the impact of perceived personal problems was relatively strong and social problems also had a negative impact. Thijs and Koomen (2009) suggest that perceptions of control influence one's emotional reactions toward others and their outcomes.

### **Rationale**

Both special and general education teachers work with students who have emotional behaviour disorders (EBD), such as CD, oppositional-defiant disorder (ODD), and attention-deficit hyperactivity disorder (ADHD) (Austin & Sciarra, 2010). There is a need for collaboration between key stakeholders in the provision of services for students who have CD. Educators, related service providers, and the child all play an important role in designing and implementing effective interventions. Therefore, it is imperative to provide educators with the information necessary to begin this emerging collaborative process.

### **Theoretical Framework**

The theoretical foundation that served as the foundation for the present project was Bandura's social learning theory (1978). A social learning or social cognitive analysis of aggression suggests that aggression is learned through direct consequences of aggressive and nonaggressive acts and through observation of aggression and its consequences. It presumes that people are shaped by the interactions between their behaviours, thoughts, and environmental conditions that set the occasion for behaviour or that reinforce or punish it (Bandura, 1978).

According to Bandura, people learn aggressive responses by observing models or examples. They are increasingly likely to imitate aggressive models of high social status

and when they see that the models receive reinforcement or do not receive punishment for their aggressive behaviour (Bandura, 1978). The factors that maintain aggression include three types of reinforcement: external reinforcement (i.e., tangible rewards, social status rewards, removal of aversive conditions, expressions of injury or suffering by the victim), vicarious reinforcement (i.e., gratification obtained by observing others gain rewards through aggression), and self-reinforcement (i.e., self-congratulation or increased self-esteem following successful aggression). Punishment is another factor that can maintain aggression when it causes pain, when there are no positive alternatives to the punished response, when punishment is delayed or inconsistent, or when punishment provides a model of aggressive behaviour (Bandura, 1978).

Social learning theory believes that aggression begets aggression. Exposure to delinquent subcultures, televised violence, and violent video games are identified as some of the environmental conditions that foster aggressive behaviour (Bandura, 1978). Likewise, families of aggressive children are characterized by high rates of aggression.

The teaching-learning process involved in aggression includes reciprocal effects that influence social, emotional, and academic development (Bandura, 1978). Aggressive children are more likely to be rejected by their peers, parents, and other adults. Academic failure is also a concern for these individuals (Bandura, 1978). When the social environment provides these aversive conditions, the individual may develop low self-concept and identify themselves in primarily negative terms. In coercive situations, aggressive children are frequently successful in overcoming others by being more aversive or persistent (Bandura, 1978).

### **Importance of the Study**

Students who have CD have been found to disrupt the regular pattern of the classroom by refusing to comply with classroom rules, school guidelines, or behave in a socially acceptable way despite intellectual ability (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). These students require a great deal of teachers' attention and management. Educators have reported feelings of frustration, anger, and resentment when working with students who have conduct disorder (Austin & Sciarra, 2010). However, students with CD are in desperate need of positive learning and success experiences. Recognition of this is key to changing the pattern of failure these students are accustomed to. If teachers can better understand the nature of this disorder and have available a repertoire of effective, research-based interventions, they are much less likely to feel overwhelmed by the disruptive behaviours exhibited by affected students.

### **Scope and Limitations of the Study**

There are several limitations of this project that should be recognized. First, the development of the handbook *Conduct Disorder: A Handbook for Elementary School Educators* was partially based on the findings of the needs assessment. Regardless of the documented necessity for a resource to facilitate the understanding of CD, the needs assessment was limited to 3 participants. A larger sample of participants would have offered a greater representation of the needs of educators with regards to CD and how to improve the academic experience for students who have CD.

Secondly, a multisystem treatment strategy, that incorporates family systems and takes into account other systems that affect the student, has demonstrated the greatest benefit for students with CD (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). While



teachers cannot provide the therapeutic interventions, they are able to provide coordination of services with families and other social units.

A third and final limitation of this research is that the handbook offered a condensed version of the literature on child-onset and adolescent-onset CD. Within the scope of this research, it was necessary to conduct an applicable and effective dissemination of the background information of CD and suggested strategies for educators.

### **Objectives of the Handbook**

*Conduct Disorder: A Handbook for Elementary School Educators* was developed following the specific objectives listed below:

1. Educators will be able to identify the behavioural, cognitive, and social characteristics of CD.
2. Educators will be able to conceptualize the epidemiology (i.e. prevalence, identification, and diagnosis) of CD.
3. Educators will recognize the intervention and treatment plans available for students with CD.
4. Educators will evaluate the handbook for practicality, efficiency, and relevance as it will be implemented into the curriculum.

The aforementioned objectives will be revisited in both Chapter Three and Chapter Five as it pertains to methodology and evaluation, respectively.

### **Research Ethics**

This project has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [14-037-DIBIASE]. Ethical clearance has also been received by a school board in Southern Ontario.

### **Outline of the Remainder of the Document**

This project is divided into five main chapters. Following an introductory chapter, chapter two is a critical review of the theoretical and empirical literature on CD. The characteristics, prevalence, diagnosis, prevention, and intervention are discussed in this chapter. Consideration is given to the theoretical framework that was used as a foundation for the development of the handbook. Chapter Three provides a detailed description of the methodology used to develop the handbook and reports the results of the needs assessment. The handbook, *Conduct Disorder: A Handbook for Elementary School Educators* is presented in Chapter Four. Chapter Five is a summary of the project and includes an evaluation of the handbook, theoretical and practical implications, conclusions, and suggestions for further research.

### **Definition of Terms**

Adolescence:	The transition period between childhood and adulthood. It begins around 12 years of age and ends at 18 years of age (Singh et al., 2007).
Callous and Unemotional Behaviour:	Behaviour marked by an absence of guilt, participation in novel and risk-taking behaviours, and insensitivity to punitive consequences for behaviour (Austin & Sciarra, 2010).

Conduct Disorder:	A persistent pattern of antisocial behaviour that violates the basic rights of others and age-appropriate societal norms (Singh et al., 2007).
Comorbidity:	Multiple disorders involving complex gene interactions (Kauffman & Landrum, 2013).
Covert Aggression (Socialized):	Antisocial acts, such as vandalism or fire setting, which are intentionally hidden from others (Kauffman & Landrum, 2013).
Externalizing Behaviour:	Aggressive, acting-out behaviours that are overtly displayed (Austin & Sciarra, 2010; Kaufman & Landrum, 2013).
Internalizing Behaviour:	Social withdrawal (e.g. Shyness, anxiety, depression). Behaviours are more difficult to observe (Austin & Sciarra, 2010; Kaufman & Landrum, 2013).
Intervention:	An approach to treatment of CD or conduct problems in the form of a method, program, or strategy (Kauffman &

Landrum, 2013).

Mainstream Classroom:

A General education classroom in which students receive special education services for less than 21% of the school day (Evans, Weiss, & Cullinan, 2012).

Oppositional Defiant Disorder (ODD):

Patterns of negativistic, hostile, and defiant behaviour that is markedly different from normally developing children of the same age (Kaufman & Landrum, 2013).

Overt Aggression (Undersocialized):

Acts of hitting, pushing, kicking, and threatening (Austin & Sciarra, 2010).

Punishment:

Any consequence that results in a decline in the rate or strength of a punished behaviour (Kauffman & Landrum, 2013).

Reinforcement:

A reward or a consequence following a behaviour, that increases the likelihood of that behaviour recurring. For example, a reward can be something one gets (i.e., a positive reinforcer) or something one gets rid of (i.e., a negative reinforcer)

(Kauffman & Landrum, 2013).

### Social Learning Theory

Albert Bandura's theory that suggests that behaviour is a result of reciprocal influences among the environment (both social and physical), personal factors, and the individual's behaviour itself (Bandura 1978; Kauffman & Landrum, 2013).

## CHAPTER TWO: REVIEW OF THE LITERATURE

*Teach me to feel another's woe, to hide the fault I see, that mercy I to others show, that mercy show to me.*

(Alexander Pope, retrieved July 4, 2014, from BrainyQuote.com)

### Organization of the Literature Review

This chapter examined the recent empirical research regarding conduct disorder among children and adolescents. The typical school experience of students with conduct disorder is highly negative and lends to further maladjustment. At school, they often experience highly punitive discipline and the attention given to their nonaggressive, positive behaviours is limited (Kauffman & Landrum, 2013). A review of the empirical research on CD provided a framework for the development of an informative and practical resource for teachers in the form of a handbook outlining research-based strategies and techniques that can be used when working with adolescents with CD. This chapter consists of three main sections: (1) theoretical framework; (2) overview of CD among children and adolescents; and (3) intervention strategies.

The first section of this chapter provides an overview of the literature on CD including characteristics, prevalence, and diagnosis. In the second section, consideration is given to Bandura's social learning theory as a theoretical framework for this project. A social learning analysis is then used to explore causal factors. The final section reviews current empirical evidence concerning the prevention and intervention of the disorder.

### Overview of Conduct Disorder among Children and Adolescents

#### Definition of Conduct Disorder

Conduct Disorder (CD) constitutes a major diagnostic category among disruptive

disorders in childhood and adolescence and is one of the most common reasons for referral of children and adolescents to mental health treatment centres (Austin & Sciarra, 2010). It is not uncommon for adolescents to engage in some form of risk-taking behaviour, such as underage drinking, truancy, or early sexual activity (Austin & Sciarra, 2010). An estimated 70% of adolescents participate in some delinquent behaviour, making these behaviours a part of the profile for normal behaviour (Austin & Sciarra, 2010). However, a child or youth who is diagnosed with CD shows a persistent pattern of antisocial behaviour that significantly impairs their everyday functioning at home or at school or leads other people to conclude that the child is unmanageable (Kauffman & Landrum, 2013). According to the *Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth Edition* (DSM-IV-TR) an individual with CD engages in a repetitive and persistent pattern of behaviour that violates the basic rights of others or major age-appropriate societal norms. The DSM-IV-TR outlines 15 criteria, three of which must be present in the past 12 months, and one of the criteria present in the past 6 months. The symptom categories include: physical aggression or threats of harm to people or animals; destruction of property; acts of deceitfulness or theft; and serious violations of age-appropriate rules (Ercan et al., 2011). *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) adds callous-unemotional traits as a specifier to the diagnosis of CD. The CU specifier includes the presence of two or more of the following CU traits: a) lack of remorse or guilt, b) callous-lack of empathy, c) shallow or deficient affect, and d) unconcerned about performance (Colins & Vermeiren, 2013).

### **Classification of Conduct Disorder**

CD is divided into two categories according to the age of onset: child-onset type

and adolescent-onset type. Child-onset type develops before 8-years of age. More than 50% of individuals with child-onset type continue with serious problems in adulthood, such as disrupted and violent relationships, vocational problems, and substance abuse (Austin & Sciarra, 2010). They are more likely to drop out of school, and 25-40% develops adult antisocial personality disorder (Austin & Sciarra, 2010). Adolescent-onset type develops after 10-years of age, typically with the onset of puberty. Approximately 85% of individuals with adolescent-onset type show an absence of antisocial behaviour by their early twenties (Austin & Sciarra, 2010). Since children tend to exhibit less overt aggression as they grow older, antisocial behaviour must be judged with reference to chronological age (Kauffman & Landrum, 2013). There are also three levels of severity of CD based on the number of conduct problems presented: mild (resulting in only minor harm to others), moderate or severe (causing considerable harm to others) (Austin & Sciarra, 2010; Kauffman & Landrum, 2013).

There are two broad forms of conduct disorder. Overt aggression or undersocialized CD is characterized by acting out toward others verbally and physically (e.g., hitting, pushing, kicking, and threatening) (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). Covert aggression or socialized CD is more difficult to observe and assess and is characterized by antisocial behaviour (e.g., stealing, lying, fire setting, and vandalism) (Kauffman & Landrum, 2013). Covert aggression is much more difficult than overt aggression to observe and assess (Kauffman & Landrum, 2013). Children can be “versatile” and show both overt and covert forms of CD. Compared to children who only engage in one type of antisocial behaviour, children who are versatile generally have more severe problems and their prognosis is worse (Kauffman & Landrum, 2013).



Aggression can also be classified as proactive or reactive. Proactive aggression stems from a linkage of aggression to an anticipated positive outcome. It is characterized by low distress and high levels of excitement and interest (Pahdy, Saxena, Remsing, Huemer, Plattner, & Steiner, 2011). Compared to reactive aggression, children who exhibit proactive aggression are more likely to have a positive prognosis when it comes to decreasing the frequency of aggressive behaviours (Austin & Sciarra, 2010). Reactive aggression is retaliatory and is induced by the presence of a real or perceived threat. It is characterized by high distress and poor restraint (Pahdy et al., 2011). Children who exhibit reactive aggression show deficits in social information processing and have a tendency to turn neutral encounters into a fight (Austin & Sciarra, 2010). In relation to the DSM-V's addition of callous-unemotional traits as a specifier to the diagnosis of CD, callous-unemotional children are more proactive their aggression and suffer from an absence of guilt. They are more likely to participate in risk-taking behaviours without being concerned about the punitive consequences for their behaviour (Austin & Sciarra, 2010).

### **Prevalence of Conduct Disorder**

There are difficulties in estimating the prevalence rates for CD because of the use of different criteria, the methods used to assess these criteria (e.g. Child reports versus parent reports), and the variations that occur at different ages and among different subgroups (e.g. Males versus females) (Austin & Sciarra, 2010). Still, approximately 6% to 16% of boys and 2% to 9% of girls under the age of 18 are diagnosed with CD (Kauffman & Landrum, 2013). The male to female ratio ranges from 2:1 to 4:1 (Austin & Sciarra, 2010). Child-onset type CD is more common among boys, but before the age of 5 rates are

equivalent for both sexes (Austin & Sciarra, 2010). While boys tend to exhibit more overtly aggressive behaviours, girls are more likely to exhibit less overtly aggressive behaviour (Kauffman & Landrum, 2013). The differences in rates of CD among ethnic groups may be contextual. For example, African American youth have higher rates of CD compared to Caucasian youth; however there is a greater percentage of children of colour living in neighbourhoods with higher rates of crime, poverty, and violence (Austin & Sciarra, 2010).

### **Comorbidities for Conduct Disorder**

ODD, ADHD, and CD are closely linked (Kauffman & Landrum, 2013). CD is also frequently comorbid with learning disabilities, anxiety, and depression (Austin & Sciarra, 2010). ADHD is the most common comorbid disorder with CD and is more frequent among individuals diagnosed with child-onset type CD. Individuals within this subgroup display more chronic delinquency, more severe aggression during adolescence, and more violent offences in adulthood (Austin & Sciarra, 2010). There are also high rates of anxiety and depression among those diagnosed with CD. Approximately 15 to 31% of children with CD have depression (Austin & Sciarra, 2010).

### **Assessment of Conduct Disorder**

The assessment of CD needs to be multimethod, multiinformant, and should occur over time. The diagnosis of CD is complicated by the high comorbidity of symptoms of CD and other diagnoses (Austin & Sciarra, 2010). Recognizing that diagnosis is not an easy task, at minimum, the use of an interview, rating scales, and observational data should all be included in the assessment to gather as much information as possible. Academic and clinical records should be consulted as well (Austin & Sciarra, 2010). Assessment should

not solely focus on behavioural challenges. Instead, prosocial skills should be included to understand what social skills a child has and to determine their standing among their peers (Kauffman & Landrum, 2013). The collection of data is not only used to confirm a diagnosis of CD, but also to develop an effective intervention (Austin & Sciarra, 2010).

### ***Interviews to Assess Conduct Disorder***

Interviews can be unstructured or structured. Unstructured interviews help to build rapport and are commonly used by clinicians. Still, unstructured interviews can be questionable in terms of reliability and validity (Austin & Sciarra, 2010). There are several semi-structured interviews that exist for diagnosing conduct problems such as, the Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS; Spitzer, Endicott, Loth, McDonald-Scott, & Wasek, 1998) and sections of the Child Assessment Schedule (CAS; Hodges, Kline, Stern, Cytryn, & McKnew, 1982) (Austin & Sciarra, 2010). Structured instruments can also be helpful in recognizing and diagnosing CD. Structured interviews are time consuming and do not usually include normative data. Some examples of structured instruments that use the DSM-IV criteria for CD include the Diagnostic Interview Schedule for Children (DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) and the Diagnostic Interview for Children and Adolescents (DICA-IV; Welner, Reich, Herjanic, & Jung, 1987)(Austin & Sciarra, 2010).

### ***Rating Scales for Assessing Conduct Disorder***

The antisocial behaviour characterizing CD is included on nearly all behaviour problem checklists and behaviour rating scales (Austin & Sciarra, 2010). It is important to use rating scales that have multiple dimensions to assess the challenges that children might have in addition to CD (Kauffman & Landrum, 2010). Self-reports or reports from

significant others (e.g., parents, peers, and teachers) have an advantage of being relatively fast to administer. Unlike unstructured instruments, these measures use normative data (Austin & Sciarra, 2010). Child norms should be compared to others of the same age and gender (Kauffman & Landrum, 2013). While self-reports are frequently used among adult populations, their use with children and adolescents can be problematic because these populations might not see themselves as having a problem. Therefore there is greater reliability given to reports from significant others (Austin & Sciarra, 2010). The Behaviour Assessment System for Children (BASC; Reynolds & Kamphaus, 1992) is an example of a multiinformant measure for the child, parent, and teacher. It is used to measure adaptive functioning, clinical categories (e.g., depression and anxiety), and taps into CD (Austin & Sciarra, 2010). An example of a parent report is the Eyeberg Child Behaviour Inventory (ECBI; Eyeberg & Robinson, 1983). It primarily assesses problems in the home setting, such as fighting. The ECBI includes a teacher report form, the Sutter-Eyeberg Student Behaviour Inventory (SESBI; Eyeberg & Pincus, 1999) (Austin & Sciarra, 2010). In addition, broadband measures of psychopathology can be used to confirm a diagnosis of CD. Like the ECBI, the Child Behaviour Checklist (CBCL) includes a teacher report form and a school behaviour checklist (Austin & Sciarra, 2010). Self-reports and ratings from significant others must always be supplemented by direct observation of children and youth in several different settings (Kauffman & Landrum, 2013).

### ***Direct Observation for Conduct Disorder***

Even though direct observation is considered to be less biased than child, parent, and teacher reports, it can be time-consuming and complicated. Characteristics of CD, such as manipulation and deceit, can reduce the reliability of observations. Observations should

occur in several social contexts, including the family, community, and school (Kauffman & Landrum, 2013). In addition to parent reports, the BASC and CBCL include observation scheduled for coding classroom and group interactions (Austin & Sciarra, 2010). After a designated time period, the observer completes a checklist of behaviour indicators. Direct observation of parent-child interactions is recommended for differentiating a diagnosis of CD (Austin & Sciarra, 2010). An example of a parent child observation scale is the Dyadic Parent-Child Interaction Coding System (DPICS; Eyeberg & Robinson, 1983). During parent-child observations, communication patterns, positive parenting behaviours, and the child's response to parental demands are observed in structured (i.e., parent-directed play, parent-directed chore situations) and unstructured activity (i.e. Free play). An argument producing discussion topic or problem-solving task can be substituted for play activity for adolescents (Austin & Sciarra, 2010).

### ***Functional Behavioural Assessment for Conduct Disorder***

To effectively address behaviour problems, their cause needs to be identified. Functional behavioural assessment (FBA) is a systematic process used to determine the purpose that an individual's specific misbehaviour serves to create a behavioural intervention plan (BIP) (Austin & Sciarra, 2010). To create a successful behavioural assessment, collaboration among the child's teachers, parents, and related service providers is important. Classroom teachers can effectively employ the behavioural assessment process (Austin & Sciarra, 2010). First, the teacher identifies and describes a target problem behaviour and collects baseline data and academic performance information. Next, the teacher describes the environmental and setting demands (Austin & Sciarra, 2010). Before developing a hypothesis, a complete direct observation is completed. The

hypothesis is tested by assessing the effectiveness of the BIP in reducing the target problem behaviour and increasing more appropriate behavioural responses (Austin & Sciarra, 2010).

### **Theoretical Framework**

According to Bandura (1978) psychological theories of aggression are based on individual physically injurious acts that are aversively motivated, attributing aggression to a narrow set of instigators. Within these theories, the purpose aggression serves is limited. Bandura (1978) argues that aggression is a multifaceted phenomenon that has many causal factors and serves diverse purposes. Therefore, a complete theory of aggression needs to be broad in scope to include a larger set of variables that influence various facets of aggression. It must explain how aggressive patterns are developed, what provokes people to behave aggressively, and what sustains aggressive actions after they have been initiated. Bandura (1978) expands on the determinants of these three aspects of aggression using the framework of social learning theory.

#### ***How are aggressive patterns developed?***

Social learning theory of aggression acknowledges that learning can result from direct experience, but further suggests that learning can occur on a vicarious basis by observing the behaviour of others and its consequences (Bandura, 1978). This capacity to learn by observation allows us to develop patterns of behaviour without having to form them gradually through trial and error. Bandura (1978) suggests three principal sources from which aggressive styles of behaviour may be adopted. The first principal source is family members. Parents that solve problems with aggressive solutions have children who tend to use similar aggressive solutions in dealing with others (Bandura, 1978). The second

principal source is the subculture in which people reside. Aggression is more common in communities in which aggressive models live and fighting skills are regarded as valued attributes (Bandura, 1978). The third principal source from which aggressive styles of behaviour may be adopted is the abundant symbolic modelling provided by the mass media. Bandura (1978) refers to television as “an effective tutor” and suggests that televised modelling of violent conduct provides unlimited opportunities to learn aggressive behaviour (p.15). Not only does televised violence teach aggressive styles of conduct, it can alter restraints over aggressive behaviour, desensitizes and habituates people to violence, and alters peoples' images of reality, influencing many of their actions.

Children who have been previously exposed to interpersonal violence are less likely to intervene in escalating aggression between children they are overseeing. Bandura (1978) explains that when a new behaviour is introduced by a salient example, it is adopted, and then it is either stabilizes or is discarded depending on its functional value. Modelling and reinforcement work together in the social learning of aggression in everyday life. Aggressive patterns are learned through observation, and altered through reinforced practice (Bandura, 1978).

A study on incidental learning by Bandura, Ross, and Ross (1961) exposed children to aggressive and nonaggressive adult models to test for the amount of imitative learning in a new situation in the absence of the model. It was hypothesized that children exposed to aggressive models would reproduce aggressive acts resembling those of their models, unlike subjects who observed nonaggressive models and from those who had no prior exposure to any models. Bandura et al. (1961) considered the influence of the sex of the model and sex of the subjects on imitation.

The sample of 72 children included 36 boys and 36 girls enrolled in a Stanford University Nursery School. The children ranged in age from 37-69 months, with a mean age of 52 months (Bandura et al., 1961). There were 2 adults, a male and a female, that served in the role of the model and one female experimenter. Participants were divided into 8 experimental groups with 6 subjects in each and control group consisting of 24 children (Bandura et al., 1961). Of the experimental subjects, half were exposed to aggressive models and half were exposed to models that were subdued and nonaggressive in their behaviour. The groups were further subdivided into male and female subjects. Half of the subjects in the aggressive and nonaggressive conditions observed same-sex models, while the remaining subjects observed the models of the opposite sex (Bandura et al., 1961). The control group had no prior exposure to the adult models and was tested only in the generalization situation. Participants in the experimental and control group were matched individually on the basis of ratings of their physical aggression, verbal aggression, aggression toward inanimate objects, and aggressive inhibition in the nursery school (Bandura et al., 1961). Both judges independently rated 51 subjects to test for inter-rater agreement. A Pearson product-moment correlation ( $r = .89$ ) was obtained by summing the ratings on the four aggression scales. Subjects were arranged in triplets and randomly assigned to one of two treatment conditions or to the control group (Bandura et al., 1961).

Subjects were brought individually by the experimenter to the experimental room and the model, who was waiting in the hallway outside of the room, was invited by the experimenter to come and join in the game. The subject was escorted to one corner of the room that was structured as a play area (Bandura et al., 1961). The experimenter demonstrated how the child could design pictures with potato prints and stickers. The



model was escorted to the other corner where there was a table and chair, tinker toy set, a mallet, and a 5-foot inflated Bobo doll (Bandura et al., 1961). The experimenter left the room. The nonaggressive model assembled the tinker toys quietly and ignored the Bobo doll (Bandura et al., 1961). The aggressive model began by assembling the tinker toy but after a minute turned to the Bobo doll and spent the remainder of the time aggressing toward it.

Bandura et al. (1961) explain that imitative learning can be demonstrated if a model performs sufficiently novel patterns of responses that are unlikely to occur independently of the observation of the behaviour of a model and if a subject reproduces these behaviours in substantially identical form. Therefore, the model exhibited specific aggressive acts that were to be scored as imitative responses (i.e., laid Bobo on its side, sat on it and punched it repeatedly in the nose, struck the doll on the head with the mallet, tossed it up in the air, and kicked it about the room). This sequence was repeated approximately three times and was interspersed with verbally aggressive responses (i.e., “sock him in the nose”, “hit him down”, and “kick him”) and nonaggressive comments (i.e., “he keeps coming back for more”, and “he sure is a tough fella”) (Bandura et al., 1961). After 10 minutes, the experimenter came back into the room and informed the subject that they would not go to another game room.

Bandura et al. (1961) tested for the amount of imitative learning in a different experimental room that was set off from the main nursery school building. The experimental room contained attractive toys, including a fire engine, a locomotive, a jet fighter plane, a cable car, a colourful spinning top, a doll set complete with wardrobe, a doll carriage, and a baby crib. Prior to the test for imitation, all of the subjects were subjected to

mild aggression arousal to insure that they were under some degree of instigation to aggression. Bandura et al. (1961) explain that subjects in the aggressive condition would be under weaker instigation following exposure to the models; if subjects in the nonaggressive condition expressed little aggression in the face of appropriate instigation, the presence of an inhibitory process would seem to be indicated.

In the experimental room, the experimenter explained that the toys were for the subject to play with. After approximately two minutes, when the subject was sufficiently involved with the play material, the experimenter told the subject that these were her very best toys and that she was going to reserve them for other children (Bandura et al., 1961). The subject was told that they could play with any of the toys in the next room. The experimenter and the subject entered an adjoining experimental room which contained aggressive toys (i.e., 3 foot Bobo doll, a mallet, a peg board, two dart guns, and a tether ball hanging from the ceiling with a face painted on it) and nonaggressive toys (i.e., a tea set, crayons and colouring paper, a ball, two dolls, three bears, cars and trucks, and plastic farm animals) (Bandura et al., 1961). The experimenter had to remain in the room because the children would either refuse to stay alone or would leave before the termination of the session. The experimenter avoided any interaction with the children by busying herself with paperwork at a desk in the far corner of the room (Bandura et al., 1961). The subjects spent 20 minutes in the experimental room.

The 20 minute session was divided into 5-second intervals using an electric interval timer (Bandura et al., 1961). There were 240 response units for each subject. Behaviour was rated in terms of predetermined response categories by judges who observed the session through a one-way mirror in an adjoining observation room (Bandura et al., 1961).

The male model, who was blind to the subjects' group assignment, scored the experimental sessions for all 72 children. Half of the subjects were also scored independently by a second observer to provide an estimate of inter-rater agreements. Bandura et al. (1961) report that the responses scored yielded high interscorer reliabilities with the product-moment coefficients being in the 90's.

Bandura et al. (1961) obtained three measures of imitation: imitation of physical aggression, imitative verbal aggression, and imitative nonaggressive verbal responses. Imitation of physical aggression included acts of striking the Bobo doll with the mallet, sitting on the Bobo doll and punching it in the nose, kicking the Bobo doll, and tossing it in the air. Imitative verbal aggression included repeated phrases such as “sock him”, “hit him down”, “kick him”, “throw him in the air”, and “pow” (Bandura et al., 1961). Imitative nonaggressive verbal responses included repeated phrases such as “he keeps coming back for more” or “he sure is a tough fella”. During the pretest, Bandura et al. (1961) found that a number of subjects imitated the essential components of the model's behaviour but did not perform the complete act, or directed the imitative aggressive response to a different object, other than the Bobo doll. These acts were considered partially imitative behaviour. Non-imitative aggression responses included punching, striking, slapping, or pushing the Bobo doll (Bandura et al., 1961). Non-imitative physical and verbal aggression included physically aggressive acts directed towards objects other than the Bobo doll and any hostile remarks except for those in the verbal imitation category. Aggressive gun play was scored when the subject shot darts, aimed the gun, and fired imaginary shots at objects in the room (Bandura et al., 1961). Ratings were also made of the number of behaviour units in which the subjects played nonaggressively or sat quietly and did not engage with the play

material.

Considering complete imitation of the models' behaviour, Bandura et al. (1961) found that the aggressive condition reproduced a good deal of physical and verbal aggressive behaviour that resembled the models' behaviour. The mean scored differed from those of nonaggressive and control conditions, who exhibited virtually no imitative aggression. The hypothesis that exposure to aggressive models would increase aggressive behaviour was supported (Bandura et al., 1961). The main effect of treatment conditions was highly significant for both physical and verbal imitative aggression. Approximately one-third of the subjects in the aggressive condition also repeated the models' nonaggressive verbal responses (Bandura et al., 1961). None of the subjects in nonaggressive or control groups made such remarks.

Next, Bandura et al. (1961) examined partial imitation of the models' behaviour. An analysis of variance of scores based on the subjects' use of the mallet aggressively toward the Bobo doll revealed that treatment conditions were a statistically significant source of variation. Individual sign tests revealed that, compared to the subjects in the nonaggressive condition, both the aggressive and the control groups produced significantly more mallet aggression (Bandura et al., 1961). The difference was particularly marked with regard to female subjects. Females who observed nonaggressive models performed a mean number of 0.5 mallet aggression responses, compared to mean value of 18.0 for girls in the aggressive groups and 13.1 for girls in the control groups (Bandura et al., 1961). This difference was not statistically significant. Subjects in the aggressive group also sat on the Bobo doll more often than the subjects in the nonaggressive or the control groups (Bandura et al., 1961).

Lastly, Bandura et al. (1961) report on non-imitative aggression. The treatment conditions did not influence the extent to which subjects engaged in aggressive gun play or punched the Bobo doll. The effect of conditions was highly significant in the case of the subjects' expression of non-imitative physical and verbal aggression (Bandura et al., 1961). Aggressive and nonaggressive groups differed significantly from each other, with subjects exposed to aggressive models displaying the greater amount of aggression.

Interestingly, subjects in the nonaggressive condition engaged in significantly more nonaggressive play with dolls than subjects in the aggressive and control groups (Bandura et al., 1961). In relation to subjects in the aggressive condition, subjects who observed the nonaggressive models spent more than twice as much time sitting quietly without handling any of the play material.

As well, Bandura et al. (1961) discuss the influence of sex of the model and sex of the subject on imitation. The hypothesis that boys are more likely than girls to imitate aggression exhibited by a model was only partially supported. Boys reproduced more imitative physical aggression than girls, but the groups did not differ in their imitative verbal aggression (Bandura et al., 1961). When compared to female subjects, male subjects exhibited more physical and verbal imitative aggression, more non-imitative aggression, and engaged in significantly more aggressive gun play after being exposed to the aggressive male model. Female subjects exposed to the female model performed more imitative verbal aggression and non-imitative aggression than the male subjects (Bandura et al., 1961). The mean differences did not reach statistical significance. Bandura et al. (1961) reported that in the generalization situation, the behaviour of the male model had a greater influence than the female model on the subject's behaviour. While subjects exposed

to the non-aggressive female model did not differ from the controls on any of the measures of aggression, the differences between groups for the nonaggressive male models is striking (Bandura et al., 1961). In relation to the control group, subjects exposed to the nonaggressive male model performed significantly less imitative physical aggression, less imitative verbal aggression, less mallet aggression, and less non-imitative physical and verbal aggression. Bandura et al. (196) suggest that physical aggression is a highly masculine-typed behaviour and, therefore, there is a tendency for both male and female subjects to imitate the male model to a greater degree than the female model. Verbal aggression is less sex linked, so, the greatest amount of imitation occurs in relation to the same-sex model (Bandura et al., 1961).

Bandura et al. (1961) explains that observation of cues produced by the behaviour of others is one effective means of eliciting certain forms of responses that were originally unlikely. Subjects who observed aggressive models later reproduced physical and verbal aggression, as well as nonaggressive responses, substantially identical with that of the model. Subjects who were exposed to nonaggressive models and those who had no previous exposure to any models rarely performed such responses (Bandura et al., 1961). Exposure to aggressive models can weaken inhibitory responses, thereby increasing the probability of aggressive reactions. Exposure to nonaggressive models decreased the probability of aggressive behaviour and restricted the range of behaviour emitted by the subjects (Bandura et al., 1961).

### ***What provokes people to behave aggressively?***

The frustration-aggression theory views aggression as a product of aggression, proposing that frustration generates an aggressive drive that motivates aggressive

behaviour. Bandura (1978) states that the frustration-aggression theory has a limited explanatory value, which suggests that frustration has various effects on behaviour. Bandura (1978) argues that aggression does not require frustration. Social learning theory of aggression supports an arousal- proponent response formulation over the frustration-aggression theory. Bandura (1978) identifies frustration or anger arousal as a facilitative, rather than a necessary, condition for aggression. After being frustrated, an aggressively trained child will behave more aggressively, whereas a cooperatively trained child will behave more cooperatively. For individuals who are prone to aggressive behaviour, different sources of emotional arousal can heighten their aggression (Bandura, 1978). Anger arousal dissipates quickly, but it can be easily regenerated on later occasions if the individual thinks about anger-provoking incidents.

Rather than frustration generating an aggressive drive, social learning theory believes that aversive stimulation produces a general state of emotional arousal that can facilitate a variety of responses. Bandura (1978) points to a large body of evidence that aversive stimulation, including painful treatment, deprivation or delay of rewards, personal insults, and failure obstruction, do not have uniform behaviour effects. The type of behaviour elicited is governed by how the source of arousal is cognitively appraised, the modes of response learned for coping with stress, and their relative effectiveness (Bandura, 1978). Aversive changes in the conditions of life can also provoke people to behave aggressively. Here, social learning theory can be used to explain why people react differently to similar situations (Bandura, 1978).

***What sustains such actions after they are initiated?***

According to Bandura (1978) people give up trying when they lack a sense of

personal efficacy. Social learning theory of aggression highlights anticipated positive consequences as an important determinant. Often, individuals will behave aggressively because they lack better alternatives to secure desired tangible rewards (Bandura, 1978). An individual is more likely to be aggressive when their assertive efforts at social and economic betterment have been periodically reinforced because they have some reason to expect that they can effect change by coercive action. When aggressive behaviour is reinforced periodically, it becomes more persistent (Bandura, 1978). Furthermore, aggressive styles of behaviour are adopted because they win approval and status rewards. Approval increases the specific aggressive responses that are socially reinforced, as well as other forms of aggression (Bandura, 1978). Since behaviour is extensively regulated by its consequences, injurious modes of response can be increased, eliminated, and reinstated by changing the effects they produce.

Still, in Bandura et al.'s (1961) study, subjects learned aggressive responses by observing the performance of social models without any opportunity to perform the models' behaviour in the exposure setting and without any reinforcers delivered to the models or the observers. So, in addition to positive consequences, aggressive actions are partly regulated on the basis of anticipated negative consequences (Bandura, 1978). Punishing consequences that are observed or experienced provide an individual with information about the circumstance under which aggressive behaviour is safe and when it is hazardous. Bandura (1978) outlines a number of factors that determine the effectiveness of punishment in controlling behaviour including the benefits derived through aggressive actions, the availability of securing desired goals, the likelihood that aggression will be punished, and the nature, severity, timing, and duration of aversive consequences. If



alternative means are available for people to get what they want and there is a high risk that aggressive behaviour will be punished, aggression is rapidly discarded. Nonetheless, defensive aggression is sustained more so by anticipated consequences than by its instantaneous effects (Bandura, 1978). Individuals will endure the pain of reprisals if they expect that their aggressive efforts will eventually remove deleterious conditions. For example, children who have been victimized but have eliminated the abuse by successful counteraggression eventually become highly aggressive in their behaviour (Bandura, 1978).

Still, Bandura (1978) warns that frequent use of aggression control through punishment can inadvertently promote aggression by modelling punitive modes of control. Observed consequences can change the observers' valuation of those who exercise power as well as the recipients. When a social agent, such as a teacher, misuses their power to reward and punish, they undermine the legitimacy of their authority and arouse opposition (Bandura, 1978). Aggressors may gain status among their peers when they are punished for a style of behaviour that is valued by the group.

In social learning theory, a self-system refers to “cognitive structures that provide the referential standards against which behaviour is judged, and a set of sub-functions for the perception, evaluation, and regulation of action” (Bandura, 1978, p.23). Bandura (1978) explains how behaviour produces self-reactions through a judgemental function relying on several subsidiary processes and outlines several ways in which self-generated consequences enter into the self-regulation of aggressive behaviour. At one extreme are individuals who have developed self-reinforcement codes, in which favourable judgements give rise to rewarding self-reactions. These individuals readily engage in aggressive

activities and their feelings of self-worth are enhanced from physical conquests (Bandura, 1978). There are no self-reprimands for injurious behaviour and instead, they are deterred from hurtful acts mainly by reprisal threats.

Yet, people do not ordinarily engage in harmful conduct (Bandura, 1978). It is not until they undergo cognitive reconstructing and have justified to themselves the morality of their actions that they engage in such behaviour. Reprehensible conduct is made personally and socially acceptable by portraying it in the service of moral ends (Bandura, 1978). Behaviour that was morally unacceptable becomes a source of self-pride. The change occurs through a gradual desensitization process in which participants may not fully recognize the changes they are undergoing (Bandura, 1978). Eventually, the level of aggression is increased until gruesome deeds that were once regarded as repugnant, can be committed without much distress.

### **Causal Factors Related to Conduct Disorder**

So, according to social learning theory, aggression is learned through direct consequences of aggressive and nonaggressive acts. It can also be learned through the observation of aggression and its consequences (Bandura, 1978). While there is no single cause of CD and related problems, a social learning analysis of aggression considers three major controlling influences: environmental conditions that reinforce and punish the behaviour, the behaviour itself, and the cognitive-affective (person) variables (Kauffman & Landrum, 2013).

#### *Environmental Conditions*

The first major controlling influence is the environmental conditions that reinforce and punish the behaviour. In mild, moderate, and severe forms of CD, the social

environment contributes to the disorder (Austin & Sciarra, 2010).

### *Parenting and Family Factors Impacting Conduct Disorder*

Poor parenting is one of the characteristics that is common among the majority of children and youth who exhibit antisocial behaviour. Youth diagnosed with versatile antisocial behaviour frequently come from the most disturbed family environments with inadequate parenting practises (Kauffman & Landrum, 2013). The parenting and family factors associated with CD include a lack of supervision, harsh and inconsistent punishment or expectations, and family and marital conflict (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). Children whose parents are hostile, negative, and neglectful are at the greatest risk for developing mental health problems such as antisocial and violent behaviour (Austin & Sciarra, 2010). Negative contextual factors (e.g. Poverty, stressed parents or caregivers) can contribute to the identified parenting and family factors. Families tend to be characterized by antisocial and criminal behaviour of parent and siblings, as well as physical or sexual abuse (Kauffman & Landrum, 2013).

### *School-related Factors Related to Conduct Disorder*

School-related factors include a low emphasis on academic success and lowered expectations, as well as little reinforcement or acknowledgement for schoolwork (Kauffman & Landrum, 2013). Typically developing children tend to reject their peers who are highly aggressive and disruptive during play and school activities. Those with CD tend to gravitate toward a deviant peer group, which is positively linked to disturbances in conduct (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). The peer rejection experienced by children with CD may also be related to the persistence of aggressive behaviour into adulthood (Kauffman & Landrum, 2013).

Neighbourhoods characterized by poverty and community disorganization are conducive to the development of conduct problems in children and youth. In these environments there is often an increased availability of drugs and firearms (Austin & Sciarra, 2010). There is an increased exposure to violence and racial prejudice, as well as violence in the media (Austin & Sciarra, 2010; Kauffman & Landrum, 2013).

### ***The Behaviour: Conduct Disorder***

According to Social Learning Theory, the second major controlling influence is the behaviour itself. Children with difficult temperaments are at risk for developing antisocial behaviour. They are more likely to develop low self-esteem and depressed affect (Kauffman & Landrum, 2013). CD is associated with neuropsychological deficits. More specifically, individuals with CD often have deficits in the area of executive functioning (i.e. Concentration, attention, planning, sequencing, and inhibition) (Austin & Sciarra, 2010). These challenges can lead to low achievement, reading problems, below average verbal IQ's, and school failure. Problems in executive functioning, especially attention problems, are predictive of early onset of CD in males (Kauffman & Landrum, 2013).

### ***Cognitive-affective Variables Related to Conduct Disorder***

The third major controlling influence is the cognitive-affective (person) variables. There are biological links that have been identified that are not necessarily specific to CD but to violence and aggression in general, including genetic and hormonal factors, neurotransmitter dysfunction, neurological factors, and prenatal toxin exposure (Austin & Sciarra, 2010). Genetic and biological factors have been linked to the most severe cases of CD but their role in mild to moderate cases of aggression is not as clear (Austin & Sciarra, 2010). There is a strong association between parental antisocial behaviour and parental

psychopathology and child-onset type CD, such as maternal substance abuse, anxiety, and depression. A twin study examining the different subtypes of CD found that family environment had more of an impact for adolescent-onset type CD compared to child-onset CD and comorbid ADHD. Genetic influences were a greater factor for child-onset CD (Scott, 2006). High levels of testosterone and its derivatives are associated with CD. More specifically, high levels of dehydroepiandrosterone, which is a precursor to testosterone, has been identified in males with CD (Austin & Sciarra, 2010).

Furthermore, neurotransmitter dysfunction, related to abnormal function of serotonin, has been found to play a role in aggression and lack of impulse control. Low levels of serotonin have also been linked to aggression in children (Austin & Sciarra, 2010). Neurological factors related to CD include frontal lobe damage in individuals who are prone to violence and aggression, and under-arousal of the autonomic nervous system (i.e. Slower heart rate), which is associated with adolescent antisocial behaviour and criminality in adulthood (Austin & Sciarra, 2010). Prenatal toxin exposure is also among the biological factors linked to aggression and violence. For example, prenatal and perinatal complications, maternal smoking, and substance abuse during pregnancy have been associated with behavioural problems (Austin & Sciarra, 2010). Other cognitive-affective variables include early signs of difficult behaviour, such as difficult temperaments in infancy and deficits in neuropsychological functions related to the use of language, and academic and intelligence deficits (Austin & Sciarra, 2010; Kauffman & Landrum, 2013).

### **Prevention and Intervention Treatments for Conduct Disorder**

#### **Prevention of Conduct Problems**

Social learning interventions commonly focus on stepping in early to prevent the

escalation of aggression. Colvin (1992) presents the acting-out behaviour cycle. The seven-phase cycle outlines the phases that children and youth typically go through in a cycle of acting-out behaviour (Kauffman & Landrum, 2013). The acting-out behaviour cycle can be used by teachers when thinking about intervention. The cycle begins with the *calm* phase in which the individual's behaviour is appropriate (Kauffman & Landrum, 2013). It is important to acknowledge and show approval of students in the calm phase. Next, an unresolved problem can *trigger* the first stage in moving toward a major blowup (Kauffman & Landrum, 2013). To avert further escalation, the teacher should move quickly to help the individual resolve the problem. When the problem is not resolved, the individual can move into a state of agitation and will exhibit unfocused and off task behaviour (Kauffman & Landrum, 2013). If there are indications of agitation, the teacher should use strategies to help the student avoid a blow-up, such as altering proximity, engaging the student in an alternative task, or involving the student in a plan of self-management. Agitation can lead to *acceleration* (Kauffman & Landrum, 2013). During this phase the student engages the teacher in a coercive struggle. The goal is no longer to stop the misbehaviour but to minimize further damage (Kauffman & Landrum, 2013). Prompt and unequivocal follow-through in applying the appropriate consequences is important. In the *peak* phase, the student's behaviour is out of control, and the safety of all concerned becomes a paramount concern (Kauffman & Landrum, 2013). Frequent out of control behaviour indicate a need to examine the environment and schoolwork for conditions that need to be changed. The *deescalation* phase is when the student begins to disengage from the struggle and is in a confused state (Kauffman & Landrum, 2013). The teacher should take measures to help the student cool down, restore the environment as

much as possible, and return to routine activities. Debriefing should not occur at this point and is likely to be counterproductive (Kauffman & Landrum, 2013). Finally, the student enters a recovery phase in which they are eager for busywork but are still reluctant to discuss what happened. Teachers should provide strong reinforcement for normal routines (Kauffman & Landrum, 2013). At this point, it is crucial that the student is debriefed on what led up to the problem and what alternative behaviours the student might have chosen.

### **Interventions for Treatment of Conduct Disorder**

#### ***Family-Based Intervention: Parent Management Training, Family Systems Therapy***

Parent training uses behaviour management principles taken from social learning theory. It includes training parents in how to track and monitor behaviour, training in the use of positive reinforcements and training to use mild punishment in an immediate and predictable manner (Baruch, Vrouva, & Well, 2011). Parent Management Training- the Oregon Model (PMTO) helps parents replace hostility and disregard with positive involvement and affection. It is designed to improve five parenting dimensions: skill encouragement, monitoring, problem solving, positive involvement, and effective discipline (Hagen Ogden, & Bjornebekk, 2011). In PMTO, changes in child behaviour are mediated by parenting with effective discipline being one of the most important dimensions in reducing acting-out behaviour in children with CD.

The purpose of Hagen et al.'s (2011) study was to compare results from intention-to-treat (ITT) and treatment-on-the-treated (TOT) analyses, to discuss their different implications. The study also investigated possible mechanisms of effects, including family cohesion. Hagen et al. (2011) hypothesized that families receiving PMTO would show greater improvements than would families in the regular services (RS)

condition on outcome variables such as, parent-and-teacher-rated behavioural problems and social skills, the five parenting dimensions (i.e. Skill encouragement, monitoring, problem solving, positive involvement, and effective discipline), child compliance, total aversive behaviour observed (TAB), and family cohesion. It was also hypothesized that effective discipline and family cohesion measured at treatment termination would mediate the relationship between treatment condition and child behaviour at follow-up (Hagen et al., 2011).

The sample consisted of 112 Norwegian children (90 boys and 22 girls) and their parents. Of the 112 children and families who completed the intake assessment battery, 97 families (86.6%) participated in the post-treatment and 75 families (67.5%) in the follow-up assessment. At intake, children ranged in age from 4 to 12 years (Hagen et al., 2011). The mean age of the primary caregiver was 39 years. The participants were from a middle to lower income level with 40 % of the families receiving welfare (Hagen et al., 2011). Forty-percent were single parents. Twenty-five-percent had a post-secondary degree, 53 % had finished high school, and 21 % had completed junior high or elementary school. The families had contacted the child welfare or child mental health agencies because of child conduct problems including aggression, delinquency, or disruptive classroom behaviour (Hagen et al., 2011).

With parental agreement, the participants' teachers were informed of the research project and asked to contribute with child assessments. Therapists collected the data from the parents, and teachers' data were mailed (Hagen et al., 2011). Observations of structured interaction tasks (SIT) were recorded at each local agency where therapy would normally take place. Families were given standardized instructions about seating arrangements,



information about the tasks they would be asked to complete, and were given an opportunity to ask questions. Microsocial interactions were coded using the *Family and Peer Process Code*, which is scored in real time and codes the initiator, recipient, sequence, content, and duration of the interactions (Hagen et al., 2011). The task lasted between 25 and 30 minutes and included specific tasks for the family to perform, such as problem solving, evaluation, clean-up, and planning an activity. Hagen et al. (2011) were most interested in the *TAB* dimension of the *Family and Peer Process Code* that consists of a composite score of the frequency with which each family member initiated a sequence of negative interactions. Two *TAB* scores were created, one for families in which both parents participated in SIT (the two-parent families) and one for one-parent SIT families. The videotapes were scored by coders who were blind to the group assessment of the families. The coders were trained to stable reliability, with an overall agreement rate of 80% (Hagen et al., 2011). Coders also completed a global rating inventory, the *Coder's Impression (CI)*, immediately following the microsocial coding. The *CI* reflected the coder's impressions of the family interactions (Hagen et al., 2011). The *CI* was missing for 35% of the families at follow-up.

To measure child emotional and behavioural adjustment, parents and teachers completed the *Child Behaviour Checklist (CBCL)* and the *Teacher Report Form (TRF)* (Hagen et al., 2011). *CBCL* scores were missing for 35% and *TRF* scores for 42% of the cases at the follow-up assessment. Social competence was assessed using the teacher and parent versions of the *Social Skills Rating System (SSRS)*, which were modified from a 3-point to a 4-point Likert Scale (Hagen et al., 2011). Thirty-six percent of the parent reports and 42% of the teacher reports were missing. The *Parent Daily Report (PDR)* is a

34-item index of observable child acting-out behaviours (Hagen et al., 2011). Parents responded via telephone on 3 consecutive days in a “yes” or “no” fashion to whether they had observed the particular child behaviour within the last 24 hours. The total score summed across all 3 days was computed (Hagen et al., 2011). To measure family cohesion, the Cohesion subscale from the *Family Adaptability and Cohesion Evaluation Scale* was completed by the primary caregiver. Scores were missing for 36% of the cases at follow-up. The primary caregiver also rated the availability of different types of social support using the condensed version of the *Interpersonal Support Evaluation List* (Hagen et al., 2011). Scores were missing for 39% of the cases at follow-up. Hagen et al. (2011) assessed therapeutic alliance by having the primary caregivers complete the *Working Alliance Inventory 12-item Short Form (WAI-S)* after the 3<sup>rd</sup>, 12<sup>th</sup>, and 20<sup>th</sup> therapy session (Hagen et al., 2011). The *WAI-S* was missing for 40% of the families.

The recruitment period lasted from January 2001 to April 2005. Post-treatment assessments were conducted between October 2001 and May 2006, and follow-up assessments were between January 2003 and July 2007 (Hagen et al., 2011). Families were treated individually and a typical session included role-playing of new skills, exercises, reviewing old sessions, troubleshooting, and discussing new homework assignments. Between sessions, parents were contacted with a midweek telephone call and given a chance to ask questions (Hagen et al., 2011). Therapists in the comparison group (RS) offered an active and responsible, but non-PMTO treatment alternative. Families in the RS group received treatments including: family therapy, Marte-Meo, behavioural therapy, cognitive therapy, and humanistic/ existential therapy.

Hagen et al. (2011) compared 31 baseline characteristics between the two

treatment groups and identified a few significant differences between the treatment conditions. The PMTO children were, on average, older, more likely to have older siblings, and more likely to have parents who scored lower on family cohesion and social support. There were more single-parent households in the RS group than in the PMTO group (Hagen et al., 2011). Hagen et al. (2011) defined dosage as the combined parent and child hours of treatment. Dosage was significantly higher in the PMTO group, so dosage was controlled for in all analyses of effect. A series of 2 (PMTO vs. RS) x 2 (Retention vs. Attrition) analyses of variance and chi-square tests were conducted to examine differential attrition across groups from pretreatment to follow-up. No significant main effect of retention was found (Hagen et al., 2011).

Hagen et al. (2011) ran a series of regression analyses with bootstrapped standard errors to examine treatment effects on primary and secondary outcome variables. Pretreatment scores on the outcome measure in question (i.e. Age, gender, dosage, and time between posttreatment and follow-up assessment) were controlled. A main effect for treatment condition on observed TAB for two-parent families was found ( $p < .05$ ). Furthermore, families in the PMTO condition showed less aversive behaviour in the observation task on average than did RS families at the follow-up assessment (Hagen et al., 2011).

Next, Hagen et al. (2011) wanted to examine the effects of treatment on families who received treatment. They ran a series of repeated measures analyses of covariance with Time (three levels) x Treatment condition (two levels), controlling for age, gender, dosage, and time between post-treatment and follow-up assessment for all primary and secondary outcomes. A main effect of treatment was found for three *TRF* scales. In relation

to the children in the RS group, children in the PMTO group significantly reduced their total problem behaviour, aggression, and delinquency (Hagen et al., 2011). A main effect was also found on teacher rated social skills. More specifically, in comparison to the RS children, children in the PMTO group significantly increased their social skills from intake to follow-up (Hagen et al., 2011).

Lastly, Hagen et al. (2011) investigated whether effective discipline and family cohesion functioned as mediators between treatment condition and various child outcomes assessed at follow-up. The specific indirect effects were estimated with bootstrapped standard errors using the maximum likelihood estimator. When considering effective discipline as a mediator, PDR aggression, PDR opposition, observed TAB, and parent-rated social skills were entered as dependent variables (Hagen et al., 2011). Gender, prescores of parental discipline and the child outcomes, and therapeutic alliance were entered as control variables. Treatment condition was significantly predictive of effective discipline at posttreatment (Hagen et al., 2011). Parents in the PMTO condition scored higher on effective discipline at posttreatment than did parents in the RS condition. Moreover, effective discipline at posttreatment significantly predicted less child aggression, child opposition, and observed aversive behaviour a year later, at follow-up (Hagen et al., 2011).

When considering family cohesion as a mediator, follow-up assessments of *CBCL* delinquency, *CBCL* internalizing problems, and teacher-rated social skills were entered as dependent variables. Gender, age, and social support were entered as control variables, along with all prescores (Hagen et al., 2011). At intake, the RS group scored higher than the PMTO families on social support and social support was positively associated with family

cohesion. Like effective discipline, treatment condition significantly predicted family cohesion at posttreatment (Hagen et al., 2011). PMTO families scored higher on family cohesion at treatment termination, which significantly predicted lower levels of delinquency, internalizing problems, and higher scores on teacher reported social skills a year later, at follow-up.

According to Hagen et al. (2011), the results only suggest that the intervention might make a difference. They propose that effects were not found for one-parent families because the demands that PMTO places on parents are more manageable for couples than they are for sole parents. The study found the effects of PMTO were increases in teacher-rated social skills and reductions in teacher-rated delinquency, aggression, and total problem behaviour in children, suggesting that the effects of PMTO extend into the school setting. Moreover, parents who received PMTO were rated by coders as being better at effective discipline than the RS parents at treatment termination. Kauffman and Landrum (2013) acknowledge that some behaviour may warrant punishment because they are intolerable or dangerous, but they warn that harsh punishment provokes counteraggression and coercion. While harsh punishment can result in immediate cessation of inappropriate behaviour, it also provides a powerful negative reinforcement for the punisher. The punished and the punisher can enter into a coercive style of interaction (Kauffman & Landrum, 2013). When parents manage to effectively avoid coercive cycles and institute contingent consequences for acting out behaviour, child aggression and defiance is not reinforced. When parents are able to prevent unwanted behaviour, they are in a better position to encourage their child's competencies. Likewise, the results identify effective discipline as a very important parenting dimension.

Hagen et al. (2011) outlined a few limitations to their study. First, the rate of attrition left a sample with power too low to answer questions about subgroups, to detect real differences between groups, and to reach a .05 significance level for a greater number of the indirect effects. Differential attrition was found for two of the teacher scales which could bias the results. In the ITT analysis, differential attrition was handled with the EM algorithm, which is believed to be a useful remedy for potential bias. Hagen et al. (2011) point out that attrition reflects lack of research participation, not treatment participation. The study was conducted a year after the PMTO so child behaviours could have been influenced by an experience or event outside of the research setting. The teachers were also made aware of the study and asked to contribute with child assessments. Their expectations about the performance of the child and their awareness of the study could create a bias when completing the CBCL and SSRS.

Like PMTO, Parenting with Love and Limits (PLL) is another parent-training intervention for children and youth with CD. PLL is a manualised group parent-training programme for parents of teenagers with challenging behaviour rated exemplary by the Office of Juvenile Justice and Delinquency Prevention. It can be delivered as a group and family intervention or as a parent-training programme with or without teenagers participating in the programme. PLL is intended to equip parents with strategies for managing and improving challenging behaviour (Baruch et al., 2011). The purpose of Baruch et al.'s (2011) study was to report on the outcomes of Parenting with Love and Limits (PLL). The Brandon Centre is a community-based, voluntary sector service that provides contraception, sexual health, and psychotherapy for individuals who are 12 to 21-years of age. Baruch et al. (2011) wanted to pilot parent training as an alternative to the

Brandon Centre's psychotherapy service in order to improve the impact of their service on young people presenting with antisocial behaviour.

The original sample consisted of 224 adult parents of 10-17 year old adolescents with behavioural problems who attended the Brandon Centre's parent-training programme for the first time between January 2005 and May 2008 (Baruch et al., 2011).

Approximately 77.1% of the parents who participated were mothers, 2.7% were fathers, and both parents' participation rate was 20.2%. The final sample consisted of 123 adults, who provided CBCL data pre- and post-treatment (Baruch et al., 2011). The majority of participants lived with their mother and attended mainstream school. They were primarily referred for behaviour problems at home and at school (Baruch et al., 2011). Antisocial behaviour problems (97.5%), family problems (90.9%) and school problems (81.8%) were the most common problems presented.

The *Global Assessment of Functioning Scale (GAF)* was used to estimate the young person's overall level of functioning, as described by the parent, according to the guidelines on a scale of 1 to 100 of increasing functioning (Baruch et al., 2011). In addition, the *Severity of Psychosocial Stressors Scale for Children and Adolescents (SPSS)* was used to assess the young person's psychosocial stressors, as reported by the parent, on a scale of increasing severity from 1 to 6. The *CBCL* was the primary outcome measure in the study. It was used to assess the emotional and behavioural problems of the participants, as reported by their parents (Baruch et al., 2011).

Parents referred to the PLL programme receive a consultation with one of the group facilitators (Baruch et al., 2011). Following the consultation they receive dates of sessions in writing and are sent a text message before each session as a reminder about the class.

The programme consists of six 2-hour classes that cover parent-teen interaction, behavioural contracts, appropriate consequences for high-risk challenging behaviour, praising the teenager, nurturance strategies, and how to enlist and use outside support (Baruch et al., 2011). The classes use direct teaching, role-play and DVD clips that accompany the programme. After each parent is accepted on the programme, they are sent a CBCL form to complete and return by mail (Baruch et al., 2011). At the end of the programme, usually 3 to 6 months, the parent is asked to complete the *CBCL* form for a second time. Following an interview with the young person's parent(s), the therapist assigns one or more diagnoses using a slightly modified version of *International Classification of Diseases* (ICD-10) (Baruch et al., 2011). The therapist fills out the Centre's own *Presentation of Problems Form* comprising of 34 items describing the young person's current problems.

Baruch et al. (2011) assessed the outcomes in internalizing problems, externalizing problems and total problems in three ways: comparing pre- and post-treatment *CBCL* mean scores; estimating the percentage of participants who moved from the clinical into the non-clinical range or vice versa; and estimating the presence of reliable change (RC) in the level of adaptation, which is based upon estimates of the standard error of measurement (Baruch et al., 2011). First, Baruch et al. (2011) carried out three paired samples *t* tests of pre- and post-treatment *CBCL* scores and found that there were significant decreases post-treatment for internalizing problems, externalizing problems, and total problems. An ITT analysis was also conducted because the data analyzed represented just above half (54.9%) of the total sample (Baruch et al., 2011). The decreases remained the significant for the total sample, for internalizing problems, externalizing problems, and total problems.



Upon completion of PLL, the group mean for internalizing problems changed from the clinical range to the non-clinical range (i.e. Below 60), but remained within the clinical range for externalizing problems (Baruch et al., 2011). The group mean for total problem scores changed from the clinical range to the borderline range (i.e. Below 63).

The McNemar test was used to assess the difference in the proportion of those in the clinical range between pre- and post-treatment (Baruch et al., 2011). A score of 60 was used as the boundary between the borderline clinical and the non-clinical range. Baruch et al. (2011) found significant improvements in the proportion of the participants reporting problems in the non-clinical range for internalizing, externalizing, and total problems. Next, independent samples *t* tests and chi-square tests were conducted to test for differences in demographic, diagnostic characteristics, and *CBCL*, *GAF*, and *SPSS* scores at intake, between participants who reported positive RC after completion of the programme and participants who did not report such change. More than half of the participants reported reliable improvement for all types of problems (54.5% for internalizing, 55.3% for externalizing, and 54.5% for total problems) (Baruch et al., 2011). The rate of reliable deterioration was 12.2% for internalizing, 8.1% for externalizing, and 5.7% for total problems.

In addition, Baruch et al. (2011) selected predictors from previous independent samples *t* tests and chi-square tests and carried out binary logistic regressions, in order to identify which variables make significant independent contributions to the prediction of reliable positive change in *CBCL* internalizing scores. Independent samples *t* tests suggested that individuals whose internalizing scores were reduced reliably to have higher scores on four *CBCL* subscales pretreatment: anxious/depression, somatic complaints,

withdrawn, and attention problems (Baruch et al., 2011). The chi-square test suggested that individuals whose internalizing scores were reduced reliably to be more likely to have emotional problems, as reported by their parents during the initial interview. When these variables were entered as predictors in the logistic regression, the model was significant, but only the withdrawn subscale was a significant independent predictor of RC in internalizing scores (Baruch et al., 2011).

Individuals whose externalizing scores were reduced reliably had higher scores on pre-treatment *CBCL* social problems. These individuals were more likely to have faced developmental issues, such as separation anxiety, as reported by their parents during the initial interview (Baruch et al., 2011). When these variables were entered as predictors in the logistic regression, the model was significant. There were not any variables that were significant independent predictors of RC in externalizing scores (Baruch et al., 2011).

Individuals whose total problem scores were reduced reliably had higher scores on two pre-treatment *CBCL* subscales: withdrawn and thought problems. It is also noted that their parents had waited, on average, more week before joining the PLL programme compared to the parents of individuals whose total scores did not decrease reliably (Baruch et al., 2011). When these variables were entered as predictors in the logistic regression, the model was significant. The withdrawn subscale was the only significant independent predictor of RC in total scores (Baruch et al., 2011).

Since follow-up data were not obtained from 45% of parents who completed a *CBCL* at intake, Baruch et al. (2011) state that the findings need to be treated with caution. The findings suggest that although PLL can run as a standalone group parent training programme, its impacts may be limited in doing so. Similar to the PMTO model in Hagen

et al.'s (2011) study, the impact of the programme might have been greater if both the parent and teenager were present and sessions for parents and teenager between the group sessions were included as part of the overall intervention (Baruch et al., 2011). Using reliable change as the criterion for improvement, there were significant levels of improvement at the end of the program. According to Baruch et al. (2011), these results suggest that although young people of parents attending the programme were primarily referred for externalizing problems, the programme has a significant impact on both internalizing and externalizing problems.

As noted by Baruch et al. (2011), there are a many limitations to this study. First, the results are limited because the analysis of outcome covers only 55.8% of parents who attended the programme and completed a *CBCL* pre- and post-intervention. Next, the study does not use a parenting scale to measure parenting practices. Therefore, we do not know if changes in the young person are accompanied by changes in parenting practices. Another limitation is that the study relies only on the parental perspective for measuring the young person's emotional and behavioural problems. Measures from multiple perspectives are recommended because reports from young people and parents about emotional behavioural problems tend to not agree. Like Hagen et al. (2011), teacher reports and police records are useful sources of information in monitoring changes in antisocial behaviour. Baruch et al. (2011) did not have a control group for comparison with the group that received treatment so it cannot be said that the improvement in young people's problems occurred because of the intervention. Lastly, there was only one follow up shortly after the end of the group parent-training programme. A follow-up at 6 and 12 months would be useful in determining whether or not the programme achieves longer lasting change.

### ***Psychopharmacological Interventions for Aggression***

Stimulants, typical and atypical antipsychotics, and mood stabilizers are medical agents used to treat CD and aggression (Ercan et al., 2011). Risperidone is an atypical antipsychotic. Research has suggested that Risperidone is effective in the treatment of behavioural disturbances in children and adolescents with CD (Ercan et al., 2011). Studies of Risperidone in children with below average IQ's have suggested improvements in both social competence and problematic behaviour. It was also found to be effective for controlling aggression in children with bipolar disorder and pervasive developmental disorder (Ercan et al., 2011). The purpose of Ercan et al.'s (2011) study was to obtain preliminary data about the tolerability and efficacy of Risperidone monotherapy in otherwise normally developing preschoolers with CD and severe behavioural problems. The aim of the study was to construct baseline data for an extension study. Ercan et al. (2011) address the controversy over the appropriateness of applying DSM-IV diagnostic criteria for CD to preschool children. With some modifications based on the child's developmental level, they consider the DSM framework to be valid for identifying preschool children with disruptive behaviours. While noncompliance and aggression is more common in childhood compared to other developmental periods, Ercan et al. (2011) argue that the essential features of CD (i.e. Violation of rules and the rights of others, aggressiveness, and destructiveness) can be applied to preschool children because they are able to understand the concept of rules and can control their behaviour accordingly.

The study included a sample of patients who were referred to the study centre from the two main state hospitals of Izmir. The participants were diagnosed with CD and ADHD during their outpatient polyclinic visits (Ercan et al., 2011). No participants were on

medication at the time of their referral to the study. All of the children were from middle or low socioeconomic families (Ercan et al., 2011). Medical history revealed that the participants were severely aggressive toward their parents and other children. Preschool education is not obligatory in Turkey and none of the children attended school because of their behavioural problems. The study began with 12 children (10 boys, 2 girls) but only 8 completed the study (6 boys, 2 girls) (Ercan et al., 2011). The mean age of the participants was 42.4 months.

In relation to Hagen et al. (2011) and Baruch et al. (2011), parents of the participants were given the opportunity to take part in a parent-training program that attempted to educate parents and other family members about disruptive behaviour disorders and provide them with effective behaviour management techniques (Ercan et al., 2011). The parent-training program consisted of eight meetings (four consecutive weekly meetings, followed by four monthly meetings). Parents of four participants did not attend the meetings due to financial problems, but parents of the remaining 12 children attended the meetings (Ercan et al., 2011). Eight parents attended more than 75% of the program; the other four parents attended more than 50%. Parents did not report receiving a remarkable benefit at the end of the program (Ercan et al., 2011). Ercan et al. (2011) suggest that socioeconomic problems might have contributed to the insufficient attendance. Upon the completion of the program, medications were offered to the parents for their children. The study began after the parents signed a written informed consent.

Ercan et al. (2011) interviewed children and applied a modified form of the Turkish version of the *Kiddie-SADS Lifetime Version (K-SADS-PL)*. All participants were treated with Risperidone starting with a daily dose of either 0.125 mg/day or 0.25 mg/day,

depending on the weight of the child. The maximum dose was 1.50 mg/day, which was achieved in only one child. Two scales were used to assess disease severity and improvement (Ercan et al., 2011). The clinician completed both the *Severity (CGI-S)* and *Improvement (CGI-I)* subscales of the *Clinical Global Impression Scale (CGI)*. The *CGI-S* was filled out at the beginning of the study, during week 4, and at the end of the study (week 8) (Ercan et al., 2011). The *CGI-I* was filled out during weeks 4 and 8. The clinician and parent forms of the *Turgay DSM-IV Based Child and Adolescent Behaviour Disorders Screening and Rating Scale* were completed at the beginning of the study, during week 4, and at the end of the study to assess the severity of inattention, hyperactivity-impulsivity, opposition-defiance, and CD (Ercan et al., 2011).

Ercan et al (2011) used five measures to assess for side-effects of Risperidone in the participants. First, laboratory tests measured complete blood counts, blood biochemistry, and prolactin levels at the beginning and end of the study. Next, ECGs were recorded at the beginning and at the end of the study (Ercan et al., 2011). As a third measure, children were weighed to assess weight change at the beginning of the study and at 2-week intervals. To assess for extrapyramidal adverse effects, Ercan et al. (2011) used the *Extrapyramidal Symptom Rating Scale* at 2-week intervals beginning during week 2 of the study and performed neurological examinations at each visit to detect if extrapyramidal side effects were present. Lastly, Ercan et al. (2011) developed a checklist to evaluate probable adverse effects reported in previous literature (e.g. Somnolence, weight gain, headache, rhinitis, vomiting, dyspepsia, and an increase in prolactin). The clinician assessed the patient at each visit by asking the items on the checklist one by one.

According to Ercan et al. (2011), the Risperidone doses used in the study are

considered low; five children (62.5%) received less than 1 mg/day, two children (25%) received 1 mg/day, and one child (12.5%) received 1.5 mg/day. After 8 weeks of the trial, all 8 children were considered responders. At the beginning of the study, the mean *CGI-S* score was 6.4, indicating that all participants were severely ill, scoring 6 or 7 on the *CGI-S*. At the end of the study, there was a 78% reduction in the *CGI-S* score, with a mean *CGI-S* score of 1.4. By week 4, both parents and the clinician reported significant improvements on all four symptom areas and in global disease severity (with the exception of the IA-P subscale) after Risperidone was administered. Ercan et al. (2011) interpreted this result to mean that the beneficial effects of Risperidone appear within one month. Ercan et al. (2011) did not find any statistically significant weight gains in patients after 2 months and parents did not report increased appetites in their children. At the clinical follow-up visit, parents did not report any cognitive impairment in their children when asked. The results did show a seven fold increase in prolactin as an outcome of Risperidone but clinical disturbances did not accompany this increase. Ercan et al. (2011) warn that the potential adverse effects of hyperprolactinemia must be carefully observed and considered when treating patients who experience prolactin elevation. If medication is started, its use should be monitored closely. Ercan et al. (2011) mention that one patient's mother mistakenly gave the child a high dose of Risperidone (2.5mg instead of 0.25 mg, 0.01 mg/kg). The child developed nausea, vomiting, sedation, and acute dystonic reaction (Ercan et al., 2011). The child and his mother were referred to the nearest hospital and Risperidone treatment was stopped for a week. Ercan et al. (2011) report that no symptoms reoccurred and Risperidone tolerance was good after restarting the treatment.

Still, there are several limitations that threaten the validity of Ercan et al.'s (2011)

study. The study began with 16 participants but, because of morality, ended with only 8 participants. Four patients dropped out at the first meeting and another 4 patients withdrew because they could not attend the follow up visits (Ercan et al., 2011). The small sample limits the statistical power of their analysis. Multiple comparisons were not performed and other variables were not controlled for (Ercan et al., 2011). Therefore, Ercan et al. (2011) state that they were unable to provide a specific estimate of the statistical power used to compute sample size. They also mention a shortage of assessment tools designed for preschoolers. Age-appropriate adaptations are needed for the *T-DSM-IV* scale (Ercan et al., 2011). The short-duration of the study is another important limitation. Ercan et al. (2011) did not find any statistically significant weight gains in patients after 2 months but this might have been observed at a long-term follow-up. The researchers also mention that long-term trials are necessary because they do not know much about the long-term effects of prolactin increase in preschoolers. Ercan et al. (2011) suggest using the results of the study as hypothesis generating rather than confirmatory.

Similar to Ercan et al.'s (2011), Padhy, Saxena, Remsing, Huemer, Plattner, and Steiner (2011) examined the effectiveness of a pharmacological treatment for CD. Divalproex (DVPX) is an anticonvulsant drug that has demonstrated efficacy in seizure disorders, reducing agitation associated with bipolar disorder, and in reducing symptoms of disruptive behaviour disorders (Padhy et al., 2011). The purpose of Padhy et al.'s (2011) study was to reanalyse data from a 7-week double-blind trial of DVPX that found improved self-reported impulse control and self-restraint in adolescents with severe conduct disorder (CD). Padhy et al. (2011) divided the population into High Distress Conduct Disorder (HDCD) and Low Distress Conduct Disorder (LDCD). Padhy et al.



(2011) associated HDCD with Reactive/ Affective/ Defensive/ Impulsive (RADI) aggression. RADI aggression is characterized by high distress and poor restraint. It is induced by the presence of a real or perceived threat (Padhy et al., 2011). LDCD was associated with Proactive/ Instrumental/ Premeditated (PIP) aggression. PIP aggression stems from a linkage of aggression to an anticipated positive outcome (Padhy et al., 2011). It is characterized by low distress and high levels of excitement and interest. Padhy et al. (2011) hypothesized that the response rate to DVPX, based on the Clinical Global Impression (CGI) assessments, would be higher in subjects with HDCD (RADI) compared to subjects with LDCD (PIP). The study also wanted to determine the effects of DVPX on specific pathways that contribute to the expression of RADI aggression (Padhy et al., 2011).

The participants in the sample were male adolescents from a California Youth Authority campus. Of the 205 male adolescents with severe CD screened for participation, 70 provided consent for study participation but at the end of the study only 58 had a complete set of valid assessments (Padhy et al., 2011). In addition to providing active consent for participation, criteria included no parental objection to participation; an absence of acute psychoses, homicidality, suicidality, developmental delay, and/or active mental illness; lack of need for additional concurrent medication; a history of at least one offence against persons; and the ability to complete the screen instrument (WAI-62) with a validity score (at least 3.667) considered adequate for this study. The mean age of the sample was 15.9 years. Of the 58 participants, 25 were white; 19 were Hispanic; 9 were African American; and 5 were of another race/ethnicity (Padhy et al., 2011). A total of 41 subjects (71%) were rated as having HDCD and 17 (29%) was rated as having LDCD.

Participants were randomly assigned into one of two treatment groups: a high-dose group that received between 1,000 and 1,500 mg DVPX per day and a low-dose group that received up to 250 mg DVPX per day (Padhy et al., 2011).

The psychiatric evaluations that made up the data set came from three sources: open assessments provided by the clinical management team; blinded questionnaire-based self-assessments; and blinded assessment by an independent clinician. The clinical management team provided a “best estimate” current psychiatric diagnosis and used the *CGI* rating scale to measure the severity of illness at the beginning of the study (*CGI-S*) (Padhy et al., 2011). The diagnosis reflected DSM-IV criteria for CD. Padhy et al. (2011) used the *Achenbach Youth Self Report (YSR)*. This screening tool is used to identify the risk for psychopathology in minors. The *Achenbach YSR* was administered at study entry and exit to provide a measure of the general level and range of psychopathology (Padhy et al., 2011). Padhy et al. (2011) used a 62 item self-report questionnaire called the *Weinberger Adjustment Inventory (WAI-62)*, which addresses distress and self-restraint. The *WAI-62* was administered at baseline, endpoint, and weekly throughout the study. A second independent clinician conducted a single 1-hour interview with each subject at the study exit and provided *CGI* ratings based only on this interaction (Padhy et al., 2011). Based on reported lifetime aggression, the second independent clinician classified the type of aggression exhibited by each subject as HDCD or LDCD. The second independent clinician was blinded to other assessments, criminal and clinical history, and subjects’ self-reports (Padhy et al., 2011). The second independent clinician also estimated *CGI-S* at the beginning and end of the study and derived an estimated degree of improvement (*CGI-I*).

All statistical analysis were performed using SAS (Padhy et al., 2011). The primary outcome measure was a between-group comparison of HDCD subjects and LDCD subjects with respect to the rate of response to DVP. Of the 25 subjects in the HDCD group treated with high-dose DVP, 16 (64%) demonstrated a response, compared to 2 of 16 (12.5%) treated with low-dose DVP (Padhy et al., 2011). Of the 9 subjects in the LDCD group treated with high-dose DVP, 2 (22%) demonstrated a response. None of the 8 subjects in the LDCD group treated with low-dose DVP demonstrated a response (Padhy et al., 2011). The secondary outcome measures were between-group comparisons of HDCD and LDCD subjects with respect to weekly slopes of the mean *WAI-62* Distress and Restraint sub scores. Padhy et al. (2011) conducted a 2x2 ANOVA analysis of the effects attributable to baseline distress (HDCD VS. LDCD) and found that the slopes of the Distress sub scores during the trial were significantly lower in the HDCD group than in the LDCD group (Padhy et al., 2011). There was also a trend toward a higher slope in the Restraint sub scores for the high-dose HDCD group, compared to the high-dose LDCD group.

The results supported Padhy et al.'s (2011) hypothesis that subjects with CD subtype characterized by Reactive/ Adaptive/ Defensive/ Impulsive (RADI) aggression showed more favourable response to DVPX treatment when compared to the subtype characterized by Predatory/ Instrumental/ Premeditated (PIP) aggression. The overall DVPX response rate was significantly higher among subjects judged to have HDCD (44%), used in the study as a predictor of RADI aggression, compared to subjects judged to have LDCD (12%), an indicator of PIP aggression. However, Padhy et al. (2011) mention that the results suggest that DVPX doses less than or equal to 250 mg/ day may not be effective with respect to CD because there were only two responses overall among subjects in the

low-dose condition in the HDCD group.

Padhy et al. (2011) believe that the results suggest that HDCD and LDCD are regulated through separate pathways and discuss the role of important regulatory role for the amygdala in determining the threshold for an external trauma to have a significant emotional impact. The impact of DVPX on the Distress sub score of the WAI-62 suggests that its efficacy in RADI aggression is partially because it raises the threshold for external trauma. The effect of DVPX on the Restrain sub score suggests that it also blocks affective states from becoming overtly aggressive behaviour. Padhy et al. (2011) propose that the two forms of aggression (RADI and PIP) are important mediators of treatment response to DVPX.

Padhy et al. (2011) identify several limitations to their study. First, the unique characteristics of the participants threaten the external validity of the results. All of the participants were males from a single California Youth Authority (CYA) campus that is characterized by the youngest offender group in the CYA population. There is a relative severity of CD in the incarcerated population but CD can also be classified as mild or moderate (Kauffman & Landrum, 2009). Therefore, the response of participants with RADI aggression in the HDCD group to DVPX cannot be generalized to milder forms of CD, as well as Oppositional Defiant Disorder (ODD). Padhy et al. (2011) also recognize the small sample size and short-term focus of their study make it difficult to generalize the results to the general community and/or long-term expectations for DVPX treatment. Also, no placebo control group could be created because all of the participants were incarcerated youth so it is possible that participation in the study could have elicited an effect that influenced the results.

### ***School-Based Interventions for Conduct Problems***

Evans, Weiss, and Cullinan (2012) were interested in examining problem characteristics of students with emotional disturbances (ED) in different educational environments, the intervention strategies that their teachers used, and the relationship between problem characteristics and intervention strategies. The sample consisted of twenty K-12 teachers from 36 schools in a rural school district in the southeastern United States (Evans et al., 2012). All of the participants taught students with school-identified ED. General education teachers were defined as teachers who taught students with Individualized Education Programs (IEPs) that indicated they received special education services for less than 21% of the school day (Evans et al., 2012). At the elementary school level, general education teachers who spent the majority of the day with these students were asked to participate and in high school levels the English/language arts teachers were asked to participate. Special education teachers were defined as teachers who taught students with IEPs that indicated they received special education services 21-100% of the school day in resource, separate classroom, or separate school environments (Evans et al., 2012). General education teachers comprised 35% of the sample.

Teachers completed student characteristic surveys for one or more students with ED in their classrooms. They rated 39-items associated with the five characteristics of ED (i.e. Inability to learn, relationship problems, inappropriate behaviour, unhappiness or depression, physical symptoms or fears) using a 4-point Likert-type scale (Evans et al., 2012). Participants also completed a teacher strategies survey that listed and described 15 behavioural strategies that were compiled from reviewing current literature, teacher survey research, and by consulting other experts in the field. For each strategy, teachers indicated

how frequently they used each strategy for academic, externalizing, and internalizing problems. According to Evans et al. (2012), all teachers reported using verbal reinforcement and teacher proximity most frequently. General education teachers reported using more strategies to help students with academic concerns more than behavioural concerns. General education teachers reported using only three strategies to address externalizing behaviour and no strategies were reported to address internalizing behaviour. Evans et al. (2012) suggest that individualized interventions used in special education classrooms should be adapted to be used in mainstream classrooms and that general education teachers should receive training and support to help them implement them. Evans et al. (2012) believe that self-management and contingency contracts are two strategies that could be effective in mainstream classrooms.

Likewise, Hoff and Ervin (2012) investigated the effectiveness of a self-management intervention for decreasing disruptive behaviours in an elementary-school classroom by looking at the influence on 3 at-risk students, as well as the entire class. The study took place in a public elementary school in a Midwestern community. Teachers from four second-grade classrooms were referred to the investigator by the school psychologist for potential participant after informing the school psychologist of the disruptive behaviours they were experiencing in their classrooms (Hoff & Ervin, 2012). All of the teachers were female and the classrooms had 20-22 students. Class-wide and individual data were collected to evaluate the effects of the self-management intervention (Hoff & Ervin, 2012). One at-risk student from each classroom was identified to monitor the effects of the class-wide intervention on students who might be experiencing the most challenges and were considered for student participation based on a teacher

nomination to the project, a continuous level of disruptive behaviour (i.e. More than 2 referrals to the school's pre-referral intervention team for disruptive behaviour), and pre-baseline observations of the students' disruptive behaviour by the classroom teacher. The student from the fourth classroom did not meet the criterion for participation and a final sample of three target students was identified for study participation (Hoff & Ervin, 2012). All of the at-risk students were male and placed full time in general education classrooms.

Like Evans et al. (2012) suggested, before the implementation of the classwide self-management intervention, teachers attended a 4-hour in-service training on the use of self-management strategies in the classroom. In addition to receiving a detailed description of self-management strategies and study procedures, teachers worked together with trainers to set up the intervention in their classrooms (Hoff & Ervin, 2012). Following the in-service training, teachers met with a graduate student consultant on a biweekly basis to talk about how the self-management intervention was progressing.

Disruptive behaviour was defined as the violation of rules, defiance, classroom disruption (i.e. Interfering with an ongoing activity), yelling, aggressive interactions, and passive off-task behaviour (Hoff & Ervin, 2012). Data collectors were not told about the study hypotheses and conducted 35-minute observations two to three times per week. A post-study questionnaire was administered to the teachers and students to assess their perception of the effectiveness of the self-management intervention (Hoff & Ervin, 2012). Following the baseline phase, the teacher-directed phase was meant to teach students the classroom rating scale and to provide frequent and meaningful teacher feedback about their performance. The teacher and the trainer identified and operationally defined two or three

classroom rules (Hoff & Ervin, 2012). The students were told about the classroom rules and were informed that their teacher would be rating the class behaviour at the end of each period using a 5-point rating scale (1 being totally unacceptable and 5 being excellent). The ratings of classwide behaviour determined the number of points the class received to use towards a reward at the end of the lesson or school day (Hoff & Ervin, 2012). During the classwide self-management phase, students monitored their own behaviour and the class behaviour for each of the rules. All of the students had rating sheets on their desks and at the end of each lesson they would record their evaluations of their own behaviour and behaviour for the entire class (Hoff & Ervin, 2012). The teacher held a class vote to decide the class rating for a randomly selected rule. The ratings of the class behaviour corresponded with the number of points students received that could be used a reward off a list that the students and teacher made together (Hoff & Ervin, 2012).

Similar to Evans et al. (2012), Hoff and Ervin (2012) found that classwide self-management was an effective strategy for reducing disruptive behaviour. The disruptive behaviour of the at-risk students decreased to a level closer to their peers and the results were maintained without moving to a more intensive intervention program. The general levels of classroom disruptive behaviour also decreased. Hoff and Ervin (2012) also found that both teachers and students rated the intervention as being effective and beneficial for addressing problem behaviour.

In an attempt to add to previous research on mindfulness-based interventions, Singh et al. (2007) conducted a study to teach a mindfulness technique, *Meditation on the Soles of the Feet*, to adolescents with conduct disorder (CD) to self-regulate their aggressive behaviour. Singh et al. (2007) looked at past literature to outline some of the



common pharmacological and psychosocial interventions and their limitations in treating CD in children and adolescents. Singh et al. (2007) began with a review of literature that focuses on pharmacological and psychosocial interventions that exist for children and adolescents with CD. First, they suggest that pharmacological interventions, such as those described by Ercan et al. (2011) and Padhy et al. (2011), are not successful in treating all forms of aggression in children and adolescents with CD. This was demonstrated by Padhy et al. (2011) who found that two forms of aggression (RADI and PIP) responded differently to DVPX. Singh et al. (2007) highlight a need for psychosocial interventions to be used in combination with pharmacological interventions. Next, they look at psychosocial interventions and suggest that these interventions focus primarily on overt maladaptive behaviours. Singh et al. (2007) point out that CD is characterized by overt and covert maladaptive behaviours. Furthermore, psychosocial interventions that are delivered within a family context are limited because of the role of the family in the development and maintenance of overt behaviours (Singh et al., 2007). Lastly, Singh et al. (2007) looked at cognitive-behavioural skills training programs and state that the results of these programs are not long lasting because of limited engagement from children and adolescents with CD. By addressing the limitations of existing pharmacological and psychosocial interventions for children and adolescents with CD, Singh et al. (2007) suggest a need for mindfulness-based interventions. They considered mindfulness-based interventions to address these limitations and discuss the previous findings from their own research studies using the mindfulness technique called *Meditation on the Soles of the Feet*. Singh et al. (2007) state that *Meditation on the Soles of the Feet* has been used successfully as a technique to control physical and verbal aggression by individuals with mental illness. The

current study was an attempt to add to their research using the same technique with adolescents with CD. Singh et al. (2007) were interested in whether adolescents with CD would engage in *Meditation on the Soles of Feet* if there was a threat of being expelled from school.

The research was conducted to investigate the effects of a mindfulness-based intervention on self-regulation of aggressive behaviour for individuals with CD. Only 3 adolescents with CD were included in the study, so the results should not be generalized for all adolescents with CD. However, the results do provide an understanding for further decision making about interventions for adolescents with CD. Singh et al. (2007) introduce their own definition of mindfulness as “the awareness and nonjudgemental acceptance by a clear, calm mind of one's moment-to-moment experience without either pursuing the experience or pushing it away” (Singh et al., 2007, p. 57.). In a previous a previous study, Singh et al. used *Meditation on the Soles of the Feet* with a young male with mental retardation and mental illness in a community placement and found that he was able to control his anger by using this technique and was discharged from community living after not engaging in aggression for 6 consecutive months (Singh et al., 2007). Another study by Singh et al. assessed the effects of long-term use of *Meditation on the Soles of the Feet* by three individuals with mental illness. The participants were able to successfully control their physical aggression, and verbal aggression also decreased (Singh et al., 2007).

In the current study, Singh et al. (2007) were interested in the assessing the influence of serious external contingency (i.e., expulsion from school) on the engagement of adolescents with CD in a single-component therapy. It was hypothesized that adolescents could be taught *Meditation on the Soles of the Feet* to self-regulate the

aggressive behaviour that had previously resulted in multiple disciplinary actions against them. Singh et al. (2007) were primarily concerned with the effectiveness of teaching a mindfulness-based intervention to self-regulate overt aggression (i.e., physical and verbal aggression) in adolescents with CD.

All of the participants were in seventh-grade and were referred for therapy from their school. Their aggressive behaviour had led to each of them being at risk for expulsion from school. All of the participants were struggling academically and had been diagnosed with CD (Singh et al., 2007). Ricky was 14 years old and Caucasian. He was known as a “big bully” and engaged in fire setting (Singh et al., 2007). He had comorbid learning disabilities and had received seven inpatient psychiatric treatments, with two psychiatric admissions in a child and adolescent psychiatric hospital within the past year. Kent was 13 years old and Caucasian (Singh et al., 2007). He was aggressive to peers and cruel to animals; he had been seen torturing cats and dogs in the neighbourhood. Libby was 13 years old and Caucasian (Singh et al., 2007). She had been physically abused as a child. Libby was aggressive toward other children and was highly noncompliant (Singh et al., 2007). She had five acute admissions to a child and adolescent psychiatric hospital within the previous 2 years.

Singh et al. (2007) defined *aggression* as “any hitting, pinching, or shoving of peers” (p.58). *Bullying* was defined as “verbal aggression or physical posturing, intended to intimidate peers (Singh et al., 2007, p.58). *Fire setting* was defined as “the unauthorized setting on fire of another's property” (Singh et al., 2007, p.58). *Cruelty to animals* was defined as “any aggressive act directed at an animal” and *noncompliance* was defined as “not responding appropriately, or at all, to teacher instructions or requests” (Singh et al.,

2007, p.58). Prior to the study, two experienced data collectors collected data from the participants' school records to provide baseline data. Data on two key variables were collected for each participant: bullying and fire setting by Ricky, aggression and cruelty to animals by Kent, and aggression and noncompliance by Libby. Singh et al. (2007) state that the reliability of the data collection from school records had previously been established at 96% across six children from the same school, but unrelated to the current study. During the study, teachers collected data during school hours on instances of aggressive/ bullying acts by each of the participants and of noncompliance by Libby. Ricky completed self-reports of fire setting and Kent completed self-reports of cruelty to animals. No reliability checks were made of the adolescents' self-reported data. In addition, to check the reliability of the teacher-reported data, a student teacher collected data weekly from two class periods. Singh et al. (2007) state that the teacher and the student teacher were trained in observational data collection before the study began. The teachers' data and the student teachers' data was compared and the mean of the overall reliability across the participants' behaviours (aggression, bullying, and noncompliance) was 98% (Singh et al., 2007).

A therapist met with each adolescent separately for about 15 minutes, three times a week for 4 weeks. In the first session, the therapist and the student discussed the student's motivation to take control of their life (Singh et al., 2007). They also discussed the adolescent's interest in learning a simple way of self-regulating their aggressive behaviour. All of the participants said that they were not very interested in learning anything new because they were already in control of their lives but, agreed they needed to behave differently if they were to stay in school (Singh et al., 2007). They agreed to meet with the therapist for a session on Monday, Wednesday, and Friday for 4 weeks to learn and practice

a mindfulness technique. They agreed to use the mindfulness technique to control their aggressive behaviour in school to avoid expulsion (Singh et al., 2007).

In the second session, the therapist taught each adolescent the *Meditation on the Soles of the Feet* mindfulness technique. The training involved the therapist providing a rationale for the training (i.e. To help the adolescent control their anger before it was expressed as a socially maladaptive behaviour) and taking the adolescent through the steps of acquiring the new skill (Singh et al., 2007). The steps involve having the individual stand in a natural posture or sit with the soles of their feet flat on the floor. The individual breathes naturally and thinks back to an incident that made them angry (Singh et al., 2007). Angry thoughts are able to flow naturally through the individuals mind and their body might show sign of anger. Then the individual shifts their attention to the soles of their feet and meditates on the soles of their feet for approximately 10 to 15 minutes (Singh et al., 2007). Slowly coming out of the meditation, the individual sits quietly for a few moments before resuming their daily activities. The students were encouraged to practice the mindfulness exercise until they were able to do it automatically when an incident occurred that would typically lead the person to physical or verbal aggression (Singh et al., 2007). For the following 10 sessions, the therapist met with the adolescents to discuss their use of the *Meditation on the Soles of the Feet* technique, had them behaviourally rehearse the procedure, and went through the training steps if necessary. After the training phase, adolescents continued to practice and use the technique but with no further training (Singh et al., 2007). They met with the therapist once a month for 15 minutes to have a general discussion about their practice of mindfulness and behaviour at school and to provide their self-report data. This practice phase lasted 25 weeks (Singh et al., 2007).

The weekly data on bullying, aggression, and collateral behaviour (noncompliance, cruelty to animals, and fire setting) is presented in a table for each of the three participants. In the table, Singh et al. (2007) show the mean weekly occurrences of the target behaviours for each individual during baseline, mindfulness training, and mindfulness practice. The table illustrates a reduction in the target behaviours for all participants over a 40-week period. For each adolescent, the data is divided by target behaviour (bullying and fire setting for Ricky, aggression and cruelty for Kent, and aggression and noncompliance for Libby) and by phase (baseline, training, and practice) (Singh et al., 2007). For all three participants, the data show that aggressive behaviour or bullying decreased minimally during the mindfulness training and substantially during the 25 weeks of practice that followed training. The behaviours were not eliminated, but were reduced to a level that was tolerable at their school (Singh et al., 2007). For Ricky, fire setting did not decrease at all during the training period but was reduced by 52% during the practice period. Kent showed an 18% reduction in the frequency of his cruelty to animals during the study period. Libby's noncompliance behaviour was reduced by 4% during the study period (Singh et al., 2007).

From self-reports by the adolescents to the therapist, Singh et al. (2007) found that the adolescents only practiced mindfulness sporadically but until some of its benefits started to emerge they practiced it more. The participants also reported experiencing a number of collateral benefits for using mindfulness and felt that they would continue using the technique in the absence of formal training (Singh et al., 2007). Singh et al. (2007) also discuss follow-up data accessed through school records. According to school records, all of the participants graduated from middle school without any further threat of expulsion due to their aggressive behaviour. Therefore, Singh et al. (2007) believe that the adolescents

were able to self-regulate their aggression to avoid expulsion for at least one year after completing the practice phase.

### **Summary of the Chapter**

CD is the most severe type of disruptive behaviour disorders and is one of the most common psychiatric disorders in childhood and adolescence (Ercan, Basay, Basay, Durak, & Ozbaran, 2011). A child or youth who is diagnosed with CD shows a persistent pattern of antisocial behaviour that significantly impairs their everyday functioning at home or at school or leads other people to conclude that the child is unmanageable (Kauffman & Landrum, 2013). The symptom categories include: physical aggression or threats of harm to people or animals; destruction of property; acts of deceitfulness or theft; and serious violations of age-appropriate rules (Ercan et al., 2011).

CD is judged with reference to chronological age (Kauffman & Landrum, 2013). Child-onset type develops before 8-years of age and adolescent-onset type develops after 10-years of age (Austin & Sciarra, 2010). The DSM-IV-TR highlights the poor outcomes for children who exhibit behaviour challenges at an early age (Ercan et al., 2011). There are two broad forms of conduct disorder: overt aggression or undersocialized CD and covert aggression or socialized CD (Kauffman & Landrum, 2013). Males are more likely to be diagnosed with CD than females. There is a close link between ODD, ADHD, and CD, with ADHD being the most common comorbid disorder with CD (Austin & Sciarra, 2010; Kauffman & Landrum, 2013).

Due to the complicated nature of diagnosis, it is necessary for assessment of CD to be multimethod and multiinformant. A minimum of interviews, rating scales, and observations should be included in the assessment. FBA can be used effectively by

classroom teachers to identify the function of a specific misbehaviour (Austin & Sciarra, 2010). Provisions should be made for periodic reassessment to measure progress or the impact of intervention (Kauffman & Landrum, 2013).

There is not a single cause of CD and its related problems (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). Instead, there is a host of causal factors that can contribute to the development of aggression in children and youth. Social Learning Theory outlines three major controlling influences: environmental conditions, the behaviour itself, and cognitive-affective variables (Bandura, 1978). The more factors a child is exposed to, the greater the risk of a youth being diagnosed with CD (Kauffman & Landrum, 2013).

CD is associated with severe functional impairment and is important to treat for several reasons. The symptoms of CD can lead to academic difficulties and poor social development and mental health outcomes (Ercan et al., 2011). There is also an risk of physical injuries that may be life-threatening for the child with CD and their victims. Interventions to prevent chronic CD are most effective if they are applied early in life (Ercan et al., 2011). After examining current empirical research studies on pharmacological and parent-training interventions, there is beneficial evidence that can help to improve symptoms of CD in children and youth (Ercan et al., 2011; Hagen et al., 2011; Padhy et al., 2011; Baruch et al., 2011). Treatments should include multidisciplinary interventions because of the frequent co-occurrence of risk factors in the development of CD (Ercan et al., 2011). Due to the lack of controlled trials and evidence of pharmacological treatments, such as Divalproex and Risperidone, psychotherapeutic interventions that include multiple systems, including the family, school, and child, are recommended as first-line interventions in typically developing children (Baruch et al.,



2011; Ercan et al., 2011; Evans et al., 2012; Hagen et al., 2011; Hoff & Ervin, 2012).

### **CHAPTER THREE: METHODOLOGY**

This chapter explains the methodological procedures for the development of *Conduct Disorder: A Handbook for Elementary School Educators*. Information of the participants, duration and findings of the needs assessment, and evaluation procedures are explicated in this chapter. The creation of the conduct disorder handbook is delineated, which identifies the impact of the needs assessment, existing literature, and theoretical framework of the project. Finally a summary of the methodology is provided.

#### **A Need for the Handbook**

After conducting a comprehensive literature review of current empirical research on CD, three salient issues became apparent: 1) the large prevalence of CD among adolescents (Ercan et al., 2011; Kauffman & Landrum, 2013); 2) the adverse outcomes for children and adolescents diagnosed with CD (Ercan et al., 2011; Kauffman & Landrum, 2013; Singh et al., 2007; Evan et al., 2012); and 3) a lack of interventions adolescents with CD in mainstream classrooms (Kauffman & Landrum, 2013; Evans et al., 2012). Therefore, the development of a handbook for educators to use with students diagnosed with CD in mainstream classrooms is important.

First, CD is one of the most common psychiatric disorders in childhood and adolescence (Ercan et al., 2011; Kauffman & Landrum, 2013). Estimates of the prevalence of CD range from 6% to 16% of boys and 2% to 9% of girls under the age of 18 (Kauffman & Landrum, 2013). The severity and prevalence of CD is perceived as increasing (Kauffman & Landrum, 2013).

Next, CD is characterized by persistent antisocial behaviour that violates the rights of others as well as age-appropriate social norms. The symptom categories include:

physical aggression or threats of harm to people or animals; destruction of property; acts of deceitfulness or theft; and serious violations of age-appropriate rules (Ercan et al., 2011). These behaviours predict adverse outcomes, such as academic failure, peer rejection, and delinquency (Miner & Clarke-Stewart, 2008).

Third, a delay of years in treatment after the onset of CD is common (Kauffman & Landrum, 2013). However, it is important to address early signs and less serious acts while we still have a chance to affect them. Teachers should have a good understanding of the nature of CD and have an available repertoire of effective, research-based interventions, that can be utilized in mainstream classrooms with affected students (Austin & Sciarra, 2010).

#### *Needs Assessment for the Handbook*

Before developing the handbook, an inductive method to research was applied. A needs assessment (Appendix A) was distributed to three educators. The needs assessment was comprised of an eight item questionnaire.

#### *Participants of the Needs Assessment*

The sample of participants for the needs assessment was a convenience sample of the target population (e.g., elementary school educators in mainstream classrooms). The handbook is directed toward elementary educators in mainstream classrooms. Table 1 provides an informative description of the three educators. To ensure confidentiality, pseudonyms are allocated to each of the educational participants.

#### *Description and Duration of the Needs Assessment*

The needs assessment was a semi-structured questionnaire that consists of seven short answer questions and one question using a rating scale. It focused on educators

Table 1

*Participants in the Needs Assessment*

Participant	Gender	Current Grade(s) of Instruction	Years of Teaching Experience
1	Female	Kindergarten	2 years
2	Female	7 and 8	6 years
3	Male	3 and 4	10 years

knowledge and understanding of CD and interventions for children and youth with CD.

The needs assessment was completed by elementary school educators of a school board in South Western Ontario.

To get a general understanding of educators knowledge and understanding of CD and the interventions used for adolescents with CD, the first question on the needs assessment utilized a scale (1-strongly disagree, 2- disagree, 3- I do not know, 4- agree, 5-strongly agree) that allowed the participants to rate their viewpoint on four statements: I have extensive knowledge of conduct disorder, I am familiar with the criteria used to diagnose students with conduct disorder, I am aware of different interventions for students with conduct disorder, and I feel adequately prepared to teach students with conduct disorder in a mainstream classroom.

After completing the rating scale, the participants were asked how they would describe or define CD. The information from this question builds upon the data collected from the rating scale and was useful in determining the information that is included in the informative portion of the handbook.

In addition, participants responded to questions that focus on the specific behaviours that adolescents with CD exhibit that hinder their learning in the classroom context and the challenges that educators face when these individuals are in their classrooms. The data collected from these questions was valuable in determining what teachers think the target behaviours of interventions should be for students with CD in mainstream classrooms. The assessment also included questions that focus on the educators' knowledge of interventions for CD and their use of strategies in the classroom with students who are diagnosed with CD, as well as other students who display similar

behaviour patterns but have not been diagnosed with CD. This information was useful in determining familiarity with different interventions, and to identify which strategies are currently being used by educators. Lastly, the assessment asked the participants to provide any other suggestions that should be considered in the development of the handbook.

Participants were provided with a copy of the questionnaire and a cover letter that explained the purpose of the research. The cover letter provided the participants with instructions for the completing and returning processes. The needs assessment was delivered to the administrative assistant at each school on September 25, 2014 in a confidential envelope. Each participant was randomly assigned a participant number that was decremented on the envelope to ensure discretion of the responses. Participants were given until October 2, 2014 to complete the needs assessment questionnaire.

#### *Findings of the Needs Assessment*

The findings of the Needs Assessment were aggregated by question. Below is a summary of the findings.

##### Question #1

*Using the following scale (1-strongly disagree, 2- disagree, 3- I do not know, 4- agree, 5-strongly agree) participants were asked to circle the number which most accurately describes their position on statements about their familiarity with conduct disorder and possible treatments.*

Participant ratings are included in Table 2 below by their participant numbers. Interestingly, Participant #1 had the least amount of teaching experience and reported having extensive knowledge about CD, while Participant #2 and #3 disagreed that their knowledge about the disorder was extensive. None of the participants agreed that they

Table 2

*Educator's Perception of Their Familiarity with Conduct Disorder and Treatments*

Question #1	Strongly Disagree	Disagree	I do not Know	Agree	Strongly Agree
a) I have extensive knowledge of conduct disorder.		2,3		1	
b) I am familiar with the criteria used to diagnose students with conduct disorder.		2,3	1		
c) I am aware of different interventions for students with conduct disorder.			2	1,3	
d) I feel adequately prepared to teach students with conduct disorder in a mainstream classroom.		1,2,3			

\*Note: Numbers under each column represent participant numbers

were familiar with the criteria used to diagnose an individual with CD. Participant #1 and #3 both reported being aware of available interventions used for the treatment of CD. Even though their years of teaching experience varied, all of the participants reported that they did not feel adequately prepared to teach students with CD in mainstream classrooms.

### Question #2

*How would you define and describe conduct disorder?*

All participants cited that CD involved certain externalizing behaviours. Participant #1 and #3 indicated that the CD was characterized by disobedience or a refusal to follow rules. Participant #3 stated that the disorder affected the individual socially and emotionally.

Notably, all of the participants' attention continued to focus on overt CD and does not make mention of covert characteristics. Further, the participants do not talk about CD outside of the classroom context.

### Question #3

*What are some of the specific behaviours that students with conduct disorder exhibit that effect learning in a classroom context?*

There are common behaviours identified among participants. All three participants noted an inability or unwillingness to follow rules or teacher direction. Students with CD were described as “off-task”, “unengaged”, and “uninterested”. Participant #2 and #3 talked about unstable relationships with teachers and peers. Participant #1 and #2 mentioned verbal and physical aggression. Participant #1 referred to “a disregard for the consequences of their behaviour”. Participant #2 mentioned the academic ramifications of CD stating that “conduct problems in the classroom affect the student's learning”.



#### Question #4

*What are some of the challenges when teaching students with conduct disorder?*

All of the participants acknowledged that there are challenges when teaching students with CD. Participant #1 and #3 commented on the difficulty of finding the right strategies to use with individual students. Likewise, Participant #2 stated that “strategies specific to conduct disorder were not thoroughly explored in educational courses”. Participant #3 mentioned that “it is hard to find strategies that can work for the whole class”. Participant #2 and #3 identified the challenge of establishing consistency between school and home, with Participant #2 talking about “a lack of support from parents and caregivers”.

#### Question #5

*Please identify any treatments or intervention programs that you are aware of for children with conduct disorder.*

From the data collected from the needs assessment, the responses provided by all of the participants were short and not detailed. Participant #1 indicated that she was unaware of any intervention programs for students with CD. Participant #2 focused on strategies that be used in the classroom such as tracking sheets, behavioural contracts, and reward systems. Participant #3 mentioned a community-based program *Big Brothers, Big Sisters* but did not describe the program or its benefits for children with CD.

It would have been beneficial to include the term describe in the question to provoke more elaboration from the participants. Participants might have demonstrated a better understanding of the treatments or intervention programs mentioned.

### Question #6

*What are some strategies or programs that you have utilized in your classrooms with students with conduct disorder? Do you utilize the same strategies for students who display similar behaviour patterns, but have not been diagnosed with conduct disorder?*

Participant #2 and #3 responded that they had used the same strategies in the classroom with students who had exhibited similar behaviours as students diagnosed with CD. Participant #2 and #3 identified several teacher-led strategies such as one-on-one conversations, facilitating reflections, teacher proximity, and monitoring behaviour.

Participant #1 indicated that they had not had a student in their class diagnosed with CD and had not utilized any strategies to prevent or lessen the associated behaviour. This could suggest a lack of importance placed on early prevention and intervention for early signs of conduct problems.

### Question #7

*What are some of the elements that you feel would make a handbook for teaching students with conduct disorder effective for educators? Please consider types of strategies and information that would be most beneficial to you.*

The common elements suggested by all of the participants were: 1) including information about the characteristics and early signs of CD, and; 2) instructions for implementing classroom intervention strategies for students with CD. Participant #1 requested a quick facts sheet about CD. In addition, Participant #3 mentioned the usefulness of “resource links for teachers to find more information about the disorder”.

Referring to the aesthetics of the handbook, Participant #2 talked about the organization of the handbook, suggesting the handbook be divided into informational and

practical sections.

#### Question #8

*Are there any other comments or suggestions that you may have regarding conduct disorder and a handbook for teaching students with conduct disorder?*

All of the participants involved responded to this question. Participant #1 and #3 discussed a lack of knowledge among educators about CD. Participant #1 stated that the handbook should use terminology that is simple to comprehend. If teachers are lacking knowledge about the disorder, using unfamiliar terms would not be conducive to their use of the handbook. Participant #3 suggested extending the resource list for educators, to include resources that could be accessed by students and parents.

Participant #2 mentioned the availability of the handbook and recommended that an electronic copy of the handbook be made accessible to educators. Not only would an electronic form be more environmentally friendly, but it would make the handbook readily available in the classroom and for parents at home.

#### *Summary of the Needs Assessment and Findings*

The findings provided from the needs assessment clearly indicated that there was a lack of background knowledge about CD among the participants (Question #2 and #3). Overall, the participants reported that they lack extensive knowledge about CD and its characteristics among children and youth (Questions #1, 2, 3). Participants did not demonstrate an understanding of the forms of CD (i.e., overt, covert, and versatile) or its effects outside of the classroom context. Equally, participants did not feel adequately prepared on how to assist students with CD in their classrooms (Questions #1, #4, and #6). While participants were able to list some classroom and instructional strategies that can be

used to prevent or lessen antisocial behaviour in the classroom, they reported a challenge in identifying appropriate strategies (Questions #4, #5, and #6).

The participants identified components and characteristics that they recommend including in the development of a handbook for CD. Some of the components included information on the characteristics of CD, early signs of conduct problems, intervention strategies, and a resource list for educators (Questions #7, #8, and #9). Moreover, participants suggested avoiding the use of jargon and should be organized in a way that makes it easy to navigate (Question #7, #8, and #9).

### **Process of Development for the Handbook**

The main objective of this project was the development of a handbook for elementary school educators working with students with conduct problems in mainstream classrooms. The focus of the handbook was on antisocial behaviour exhibited by students diagnosed with CD. A review of literature on CD and aggression, in addition to the responses given in the needs assessment was contributory in the development of *Conduct Disorder: A Handbook for Elementary School Educators*.

I began by conducting a comprehensive literature review of current research on the diagnosis, prevalence, etiology, and the different treatment interventions for CD. This allowed me to gather suggestions from empirical studies and to provide research-based rationales for the strategies included in the handbook.

Furthermore, before developing a handbook for educators to use with students diagnosed with CD in mainstream classrooms, it was necessary for me to create a needs assessment. The semi-structured questionnaire consists of seven short answer questions and one question using a rating scale. A sample of educators who work with students with

conduct problems were asked to provide formative and summative feedback throughout the development of the handbook. These data influenced the information provided to educators about CD. The needs assessment also allowed educators to identify and verbalize what they would like to see in the handbook. By assessing the experiences of elementary school teachers, target behaviours and common challenges emerged from the data. This was helpful in determining what the practical component of the handbook would address.

### *Objectives of the Handbook*

The objectives of the handbook are:

1. Educators will be able to identify the behavioural, cognitive, and social characteristics of CD.
2. Educators will be able to conceptualize the epidemiology (i.e. prevalence, identification, and diagnosis) of CD.
3. Educators will recognize the intervention and treatment plans available for students with CD.
4. Educators will evaluate the handbook for practicality, efficiency, and relevance as it will be implemented into the curriculum.

### **Implementation**

*Conduct Disorder: A Handbook for Elementary School Educators* was created to be implemented by educators in mainstream classrooms in Ontario, Canada. The handbook can also be beneficial and useful for school administrators, social workers, child and youth workers, and parents. The handbook was developed from the viewpoint that with a good understanding of the nature of CD and an available repertoire of effective, research-based interventions, the school experience will improve for both teachers and students in

mainstream classrooms.

The handbook offers preventative supplementary information about CD (i.e., epidemiological information, causal factors, and intervention strategies). In addition, the handbook can be used as a hands-on resource guide that delivers suggested strategies to prevent or lessen conduct problems in the mainstream classroom.

### **Educator Evaluation of the Handbook**

*Conduct Disorder: A Handbook for Elementary School Educators* was evaluated for significance, usefulness, simplicity, and aesthetics by the same sample of educators who completed the needs assessment. Selecting the same participants to complete the evaluation questionnaire allowed educators to assess whether their needs were addressed satisfactorily. In addition, they were able to consider whether the handbook would be valuable to elementary school teachers of mainstream classrooms. The evaluation consisted of a short questionnaire. The results of the evaluation are delineated in Chapter Five.

### **Summary of the Chapter**

Due to the large prevalence and severity of CD among children and youth, school-based interventions for students displaying conduct problems is vital in minimizing adverse outcomes. Educators need to be equipped with knowledge about the nature of CD and able to implement research-based intervention strategies in mainstream classrooms.

An inductive method to research was applied during the development of this handbook. A needs assessment was distributed to a convenience sample of elementary school educators currently teaching in mainstream classrooms. The needs assessment was a semi-structured questionnaire that consists of seven short answer questions and one

question using a rating scale. It focused on educators knowledge and understanding of CD and interventions for students with CD.

Question #1 utilized a scale that allowed the participants to rate their viewpoint on four statements: I have extensive knowledge of conduct disorder, I am familiar with the criteria used to diagnose students with conduct disorder, I am aware of different interventions for students with conduct disorder, and I feel adequately prepared to teach students with conduct disorder in a mainstream classroom. Only one participant reported having extensive knowledge of CD. Two of the participants reported that they were aware of available interventions used for the treatment of CD. Still, all of the participants reported that they did not feel adequately prepared to teach students with CD in mainstream classrooms. Question #2 focused on how the participants would describe or define CD.

## **CHAPTER FOUR: CONDUCT DISORDER: A HANDBOOK**

This chapter includes *Conduct Disorder: A Handbook for Elementary School Educators*, a handbook designed to: 1) assist educators in developing a better understanding of conduct disorder and aggression; 2) provide educators with strategies and skills that can be used in the classroom to help students develop healthy social and academic skills; and 3) provide educators with a list of resources and agencies that can be shared with both parents and students. The results of the needs assessment questionnaire, theoretical and empirical research on conduct disorder among children and youth, and other resources all contributed to the creation of this handbook.

The handbook begins by defining conduct disorder and aggression and then, using a social learning approach, considers the causal factors associated with the development of conduct problems. Next, the handbook describes the various types of treatments and interventions that are most commonly used with children and youth who exhibit conduct problems. Another section focuses on strategies and activities that elementary school educators can utilize in mainstream classrooms with all students to prevent or lessen acting-out behaviours. Lastly, a list of community resources and programs is provided.



# *Conduct Disorder: A Handbook for Educators*



(Microsoft Word, version 2010)

**By: Presley Chiasson**

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## Introduction

Externalizing problems are characterized by aggressive, impulsive, and disobedient behaviour (Kauffman & Landrum, 2013). These behaviours predict adverse outcomes, such as academic failure, peer rejection, and delinquency (Kauffman & Landrum, 2013). Children vary in the frequency of externalizing behaviours at different ages and the change in frequency of externalizing behaviour over time (Miner & Clarke-Stewart, 2008). For boys and girls, the risk of externalizing behaviour is increased by a variety of personal, family, peer, and school-related factors (Kauffman & Landrum, 2013).

*Conduct Disorder* (CD) is the most severe type of disruptive behaviour disorders and is one of the most common psychiatric disorders in childhood and adolescence (Ercan, Basay, Basay, Durak, & Ozbaran, 2011). The typical school experience of students with CD is highly negative and lends to further maladjustment. At school, they often experience highly punitive discipline and the attention given to their nonaggressive, positive behaviours is limited (Kauffman & Landrum, 2013).

The most common approaches to intervention for CD include parent management training, problem-solving training, family therapy, and treatments that address the individual and multiple social systems (Kauffman & Landrum, 2013). However, with a focus on early intervention, elementary school educators need to be able predict antisocial behaviour in order to be able to prevent it. They should also be equipped with strategies and interventions that they feel confident

to use to address the academic and behavioural concerns for children and youth with conduct problems.

This handbook was developed in hopes of improving the typical school experience for children and youth with CD, and their teachers. *Conduct Disorder: A Handbook for Elementary School Educators* was created for to inform educators with the knowledge and resources needed to better understand CD. This handbook can also be utilized by administrators, guidance counsellors, social workers, and parents.

A child or youth who is diagnosed with CD shows a persistent pattern of antisocial behaviour that significantly impairs their everyday functioning at home or at school or leads other people to conclude that the child is unmanageable (Kauffman & Landrum, 2013). The symptom categories include: physical aggression or threats of harm to people or animals; destruction of property; acts of deceitfulness or theft; and serious violations of age-appropriate rules (Ercan et al., 2011). The significance and needs for this handbook is illustrated by the large prevalence of CD and its adverse outcomes, the considerable stability of the diagnosis overtime, and the risk of escalating aggressive and antisocial behaviour in untreated patients (Austin & Sciarra, 2010; Kauffman & Landrum, 2013; Minor & Clarke-Stewart, 2008). The reasoning behind the development of an informative and practical handbook for elementary school educators was predisposed by a review of current empirical literature on conduct disorder and aggression in children and youth and the findings of a needs assessment completed by three elementary school educators.

*Conduct Disorder: A Handbook for Elementary School Educators* provides educators with information, strategies, activities, and resources that can be utilized in mainstream classrooms that can be beneficial to all students, with or without conduct disorder. The information presented in the handbook is divided into two sections. The first section focuses on developing an understanding of conduct disorder and aggression. The second session includes strategies and activities that can be implemented by educators to address acting-out behaviours. Within this section, a list of community resources and programs is provided.

## **Objectives of the Handbook**

Conduct Disorder: A Handbook for Elementary School Educators is a handbook for elementary educators in mainstream classrooms that is designed to help educators to:

- Understand the epidemiology of conduct disorder (i.e., prevalence, identification, and assessment)
- Identify and classify children and youths' behaviours
- Identify the various causal factors associated with the development of conduct problems
- Recognize and understand the intervention and treatment programs available for children and youth who are diagnosed with conduct disorder
- Possess the knowledge and skills required to facilitate the improvement of the school experience for children and youth with conduct problems

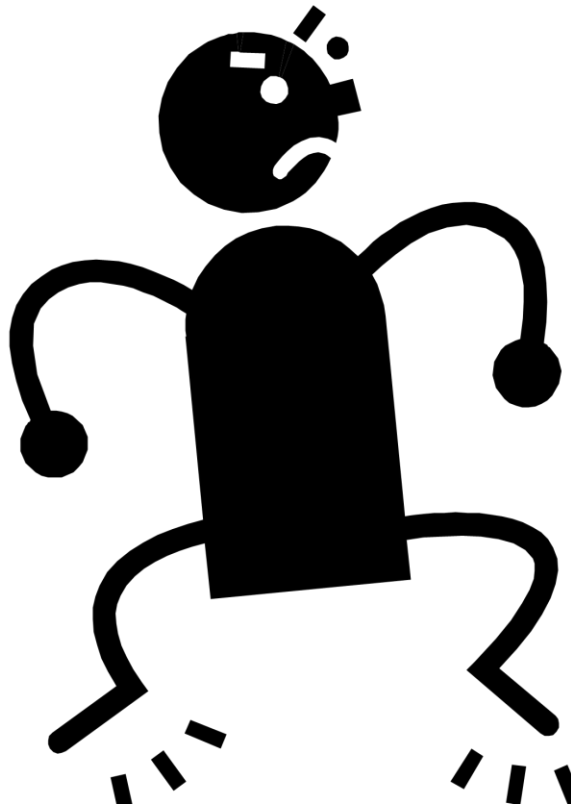
The significance of having a handbook on conduct disorder will enable educators to improve their interactions with students exhibiting problem behaviour.

Teachers' interpretations of behaviours influence their affective and disciplinary reactions to student behaviour (Lovejoy, 1996; Phillips & Lonigan, 2008).

Teachers' beliefs about children's motivations, intentions, and control over their behaviour needs to be considered when designing and implementing school-based interventions (Lovejoy, 1996). Thus, an educator needs to possess an understanding of conduct disorder and the associated causal factors in order to effectively implement strategies and skills to lessen or prevent problem behaviours in the mainstream classroom.

**Part One**

# **Understanding Conduct Disorder**



(Microsoft Word, version 2010)



## What is Conduct Disorder?

*Conduct Disorder* (CD) is the most severe type of disruptive behaviour disorders and is one of the most common psychiatric disorders in childhood and adolescence (Ercan, Basay, Basay, Durak, & Ozbaran, 2011). A child or youth who is diagnosed with CD engages in a repetitive and persistent pattern of antisocial behaviour that violates the basic rights of others and age-appropriate societal norms (Singh et al., 2007). The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition- Text Revision* (DSM-IV-TR), divides the 15 criterion behaviours into four groups: aggressive conduct that causes or threatens physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules. To receive a diagnosis of CD, children or adolescents must have exhibited at least three of 15 criterion behaviours within the previous 12 months and at least one within the previous six months (Singh et al., 2007).

Approximately 6% to 16% of boys and 2% to 9% of girls under the age of 18 are diagnosed with CD (Kauffman & Landrum, 2013). There are two broad forms of CD. Overt aggression or undersocialized CD and covert aggression or socialized CD. Children can be “versatile” and show both overt and covert forms of CD. Compared to children who only engage in one type of antisocial behaviour, children who are versatile generally have more severe problems and their prognosis is worse (Kauffman & Landrum, 2013). Table 1 provides a brief description of the two broad forms of CD.

Table 1  
*Forms of Conduct Disorder*

The two broad forms of Conduct Disorder	
Overt Aggression	Covert Aggression
<ul style="list-style-type: none"> <li>• Undersocialized CD</li> <li>• Acting out toward others verbally or physically</li> <li>• Includes characteristics such as hyperactivity, impulsiveness, irritability, stubbornness, arguing, teasing, poor peer relations, loudness, disobedience</li> <li>• Closely associated with violent behaviour (e.g., hitting, pushing, kicking, threatening)</li> <li>• These children would stand out to parents, teachers, and peers</li> </ul>	<ul style="list-style-type: none"> <li>• Socialized CD</li> <li>• Relational aggression</li> <li>• Antisocial acts such as stealing, lying, fire setting, vandalism, and truancy</li> <li>• Includes characteristics such as negativism, destructiveness, gang membership, running away, abuse of alcohol or other drugs</li> <li>• Difficult to observe and assess</li> <li>• Many of these behaviours would escape the notice of teachers or parents</li> </ul>
<ul style="list-style-type: none"> <li>• Children can be “<b>versatile</b>” and show <i>both</i> overt and covert forms of CD</li> <li>• Compared to children who only engage in one type of antisocial behaviour, these children generally have more severe problems and their prognosis is worse</li> </ul>	

Adapted from: Austin & Sciarra (2010) and Kauffman & Landrum (2013)

The DSM-IV-TR divides CD into two categories according to the age of onset: childhood- and adolescent- onset (Ercan et al., 2011). Since children tend to exhibit less overt aggression as they grow older, antisocial behaviour must be judged with reference to chronological age. CD can also be classified as mild (resulting in only minor harm to others), moderate, or severe (causing considerable harm to others) (Kauffman & Landrum, 2013). Table 2 provides a brief description of the subtypes of CD.

Table 2  
*Subtypes of Conduct Disorder*

Age of Onset	
Childhood-Onset Type	Adolescent-Onset Type
<ul style="list-style-type: none"> <li>• Early onset</li> <li>• Develops before the age of 10 or 12 years</li> <li>• More severe impairment</li> <li>• Poorer prognosis (disrupted and violent relationships, vocational problems, and substance abuse)</li> <li>• More likely to develop adult antisocial personality disorder</li> <li>• More likely to drop out of school</li> </ul>	<ul style="list-style-type: none"> <li>• Develops after the age of 10 years</li> <li>• Usually with the onset of puberty</li> <li>• An estimated 85% show an absence of antisocial behaviour by their early twenties</li> </ul>

Adapted from: Austin & Sciarra (2010) and Kauffman & Landrum (2013)

## **What is Aggression?**

Aggression can be classified as proactive or reactive. Proactive aggression stems from a linkage of aggression to an anticipated positive outcome. It is characterized by low distress and high levels of excitement and interest (Pahdy et al., 2011). Compared to reactive aggression, children who exhibit proactive aggression are more likely to have a positive prognosis when it comes to decreasing the frequency of aggressive behaviours (Austin & Sciarra, 2010). Reactive aggression is retaliatory and is induced by the presence of a real or perceived threat. It is characterized by high distress and poor restraint (Pahdy et al., 2011). Children who exhibit reactive aggression show deficits in social information processing and have a tendency to turn neutral encounters into a fight (Austin & Sciarra, 2010). Table 3 provides a summary of reactive and proactive aggression.

Table 3  
*Types of Aggression*

Types of Aggression	
Reactive Aggression	Proactive Aggression
<ul style="list-style-type: none"> <li>• Retaliatory and based on real or perceived threats</li> <li>• Deficits in social information processing</li> <li>• Tendency to employ a hostile attribution bias to ambiguous situations</li> <li>• Turn a neutral encounter into a fight</li> </ul>	<ul style="list-style-type: none"> <li>• Carefully planned and designed with a clear purpose in mind</li> <li>• Tend to have a more positive prognosis when it comes to decreasing frequency of aggressive behaviours</li> </ul>

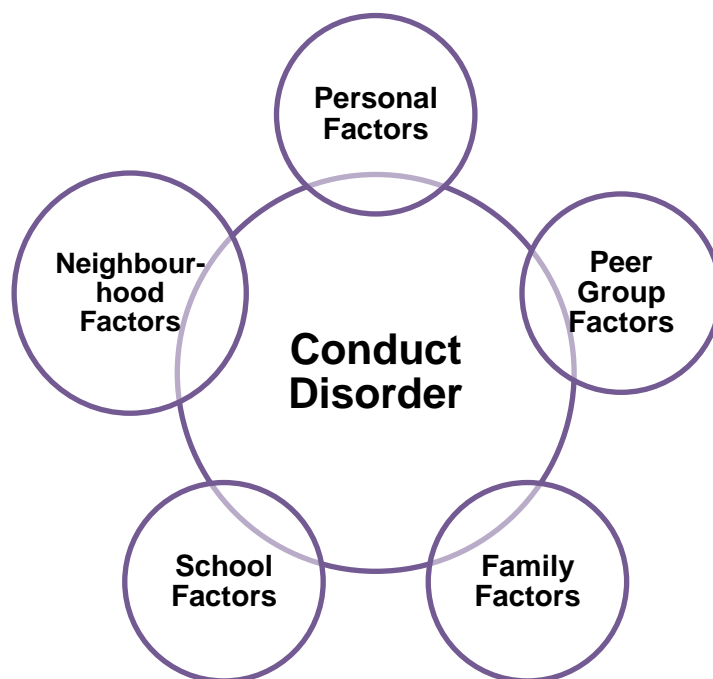
Adapted from: Austin & Sciarra (2010) and Kauffman & Landrum (2013)

## **Causal Factors and Characteristics Associated with Conduct Disorder**

There is not a single cause of CD and its related problems (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). Instead, there is a host of causal factors that can contribute to the development of aggression in children and youth. The more factors a child is exposed to, the greater the risk of a youth being diagnosed with CD (Kauffman & Landrum, 2013). Figure 1 illustrates the various causal factors associated with the development of CD. Table 4 provides a list of causal factors and characteristics associated with CD.

Figure 1

*Causal Factors Associated with Conduct Disorder*



Adapted from: Austin & Sciarra (2010) and Kauffman & Landrum (2013)



Table 4

*Causal Factors and Characteristics Associated with CD*

<b>Personal Factors</b>	<ul style="list-style-type: none"> <li>➤ Difficult, irritable temperaments</li> <li>➤ Low self-esteem and depressed affect</li> <li>➤ Deficits in the area of executive functioning (i.e., concentration, attention, planning, sequencing, and inhibition)</li> <li>➤ Below average verbal IQ's</li> <li>➤ High levels of testosterone and its derivatives</li> <li>➤ Low levels of serotonin</li> <li>➤ Prenatal and perinatal toxin exposure (e.g., maternal smoking, and substance abuse during pregnancy)</li> </ul>
<b>Peer Factors</b>	<ul style="list-style-type: none"> <li>➤ Rejected by non-antisocial peers</li> <li>➤ Gravitate toward a deviant peer group</li> <li>➤ Gang membership</li> </ul>
<b>School Factors</b>	<ul style="list-style-type: none"> <li>➤ Low emphasis on academic success</li> <li>➤ Lowered expectations</li> <li>➤ Little reinforcement or acknowledgement of schoolwork</li> <li>➤ Reading problems</li> <li>➤ School failure</li> </ul>

Table 4 Continues

<b>Neighbourhood Factors</b>	<ul style="list-style-type: none"> <li>➤ Poverty</li> <li>➤ Community disorganization</li> <li>➤ Increased availability of drugs and firearms</li> <li>➤ Increased exposure to violence and racial prejudice</li> <li>➤ Violence in the media</li> </ul>
<b>Family Factors</b>	<ul style="list-style-type: none"> <li>➤ Lack of supervision</li> <li>➤ Harsh and inconsistent punishment or expectations</li> <li>➤ Family and marital conflict</li> <li>➤ Hostile, negative, and neglectful parents</li> <li>➤ Antisocial and criminal behaviour by parents and siblings</li> <li>➤ Physical or sexual abuse</li> <li>➤ Negative contextual factors (e.g., poverty)</li> <li>➤ Parental substance abuse, anxiety, and depression</li> </ul>

Adapted from: Austin & Sciarra (2010) and Kauffman & Landrum (2013)

## **Disorders that Co-exist with Conduct Disorder**

Oppositional Defiant Disorder (ODD), Attention-Deficit Hyperactivity Disorder (ADHD), and CD are closely linked (Kauffman & Landrum, 2013). CD is also frequently comorbid with learning disabilities, anxiety, and depression (Austin & Sciarra, 2010). ADHD is the most common comorbid disorder with CD and is more frequent among individuals diagnosed with child-onset type CD. Individuals within this subgroup display more chronic delinquency, more severe aggression during adolescence, and more violent offences in adulthood (Austin & Sciarra, 2010). There are also high rates of anxiety and depression among those diagnosed with CD. Approximately 15% to 31% of children with CD have depression (Austin & Sciarra, 2010). Figure 2 illustrates the emotional and behavioural disorders (EBD) commonly associated with CD. Table 5 briefly explains the EBD's associated with CD.

Figure 2

*Conduct Disorder and Associated Emotional Behavioural Disorders*

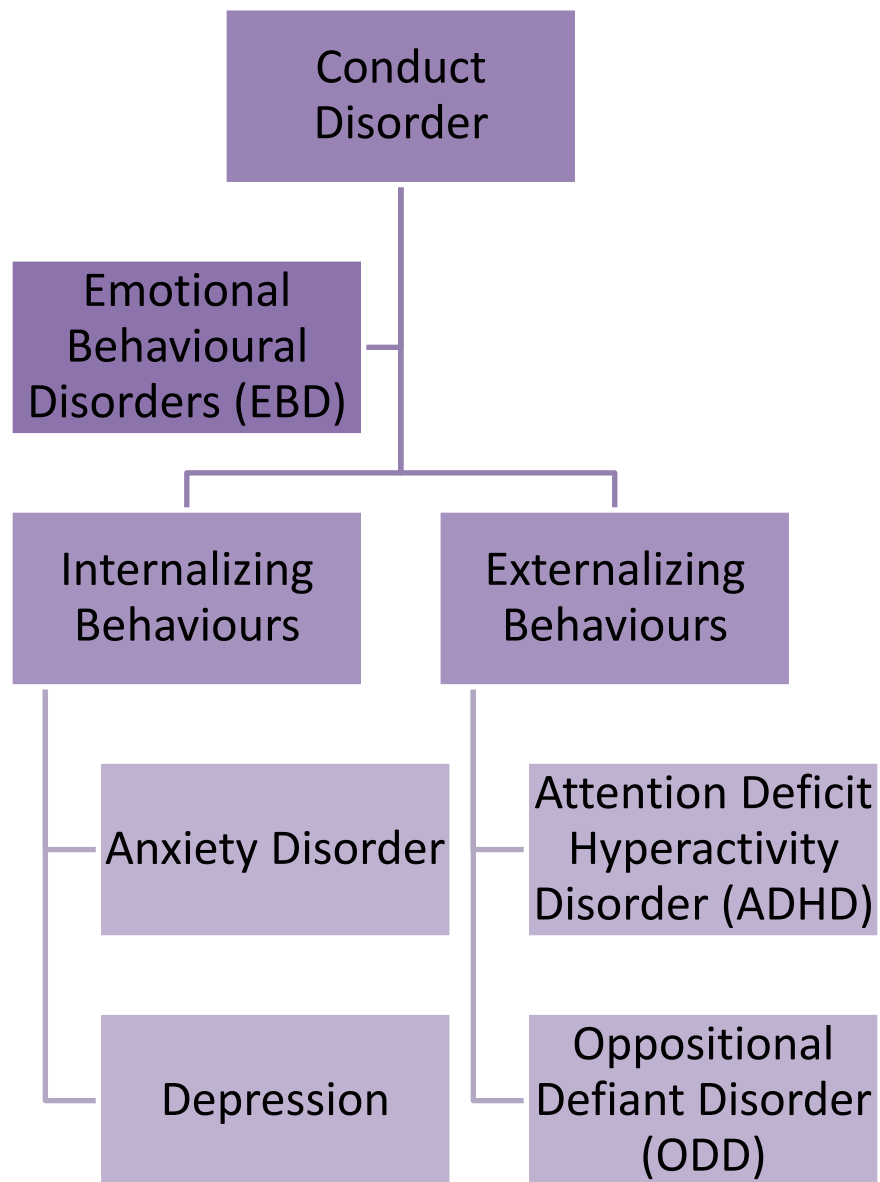


Table 5

*Emotional Behavioural Disorders Associated with Conduct Disorder*

<b>Emotional Behavioural Disorders</b>	
<p>Involve behavioural and emotional responses that are markedly different from appropriate age, culture, or ethnic norms that adversely affect educational performance</p> <p>Characteristics include:</p> <ul style="list-style-type: none"> <li>➤ An inability to learn that cannot be explained by intellectual factors</li> <li>➤ An inability to create or sustain reciprocal relationships</li> <li>➤ A pervasive mood of unhappiness or depression</li> <li>➤ Inappropriate types of behaviour or feelings in typical situations or environments</li> <li>➤ Occurrences of physical symptoms of fear attached to personal or school problems</li> </ul>	
<b>Internalizing Behaviours</b> <ul style="list-style-type: none"> <li>➤ Social withdrawal (e.g. Shyness, anxiety, depression)</li> <li>➤ Behaviours that are more difficult to observe</li> </ul>	<b>Externalizing Behaviours</b> <ul style="list-style-type: none"> <li>➤ Aggressive, acting-out behaviours that are overtly displayed</li> </ul>
<b>Anxiety</b> <ul style="list-style-type: none"> <li>➤ Constant pattern of worry and uneasiness</li> <li>➤ Can focus on specific situations (e.g., separation or social contact with strangers) or be more generalize and pervasive</li> <li>➤ Individual may experience physical problems such as stomach problems, headaches, and shakiness</li> </ul>	<b>Attention Deficit Hyperactivity Disorder (ADHD)</b> <ul style="list-style-type: none"> <li>➤ A developmental and neurobiological disorder</li> <li>➤ Characterized by inattention, impulsivity, and hyperactivity of sufficient severity and persistence</li> <li>➤ Results in impairment in social, academic, or occupational functioning</li> </ul>
<b>Depression</b> <ul style="list-style-type: none"> <li>➤ Depressed mood and loss of interest or pleasure in nearly all normal activities</li> <li>➤ Episode lasting for longer than two weeks</li> <li>➤ Individuals' emotions, thoughts, and behaviours are affected</li> </ul>	<b>Oppositional Defiant Disorder (ODD)</b> <ul style="list-style-type: none"> <li>➤ Pattern of negativistic, hostile, and defiant behaviour that is unusual for the individual's age and developmental level</li> <li>➤ Inappropriate levels of anger, irritability, hostility, and disobedience</li> </ul>

Adapted from: Austin &amp; Sciarra (2010) and Kauffman &amp; Landrum (2013)

## **Types of Treatment and Interventions for Conduct Disorder**

CD is associated with severe functional impairment and is important to treat for several reasons. The symptoms of CD can lead to academic difficulties and poor social development and mental health outcomes (Ercan et al., 2011). There is also a risk of physical injuries that may be life-threatening for the child with CD and their victims. Interventions to prevent chronic CD are most effective if they are applied early in life (Ercan et al., 2011). Treatments should include multidisciplinary interventions because of the frequent co-occurrence of risk factors in the development of CD (Ercan et al., 2011). Psychotherapeutic interventions that include multiple systems, including the family, school, and child, are recommended as first-line interventions in typically developing children (Baruch et al., 2011; Ercan et al., 2011; Evans et al., 2012; Hagen et al., 2011; Hoff & Ervin, 2012). Table 6 provides common types of treatments and interventions for CD.

Table 6

*Types of Treatments and Interventions for Conduct Disorder*

Type of Treatment/ Intervention	Description
<b>Family-Based Interventions</b>	<i>Parent-Management Training (PMT)</i>
	<ul style="list-style-type: none"> <li>➤ Primarily used for preschool and elementary school children who are showing conduct problems</li> <li>➤ Works with parents to alter their interactions with the child</li> <li>➤ Teaches parents to give clear rules, how to track and monitor behaviour, training in the use of positive reinforcements</li> <li>➤ Training to use mild punishment in an immediate and predictable manner</li> <li>➤ Shown to be effective in both the short and long term</li> <li>➤ Greater effects associated with longer-term programs</li> <li>➤ Parental resistance and psychopathology are impediments to treatment</li> </ul> <p style="text-align: center;"><i>Family Systems Therapy</i></p> <ul style="list-style-type: none"> <li>➤ Includes the entire family</li> <li>➤ Three phases               <ol style="list-style-type: none"> <li>1. Engagement and Enactment: provider meets with family and pays attention to patterns of communication, coalition, and boundaries (lacking or rigid)</li> <li>2. Behavioural Change: provider begins to interrupt familiar patterns and restore power and authority to the executive subsystems</li> <li>3. Generalization: family members are taught to apply their new learning by anticipating problems and practicing</li> </ol> </li> <li>➤ Short-term focus (6 to 12 sessions)</li> <li>➤ Difficulty engaging the entire family system</li> </ul>

Table 6 Continues

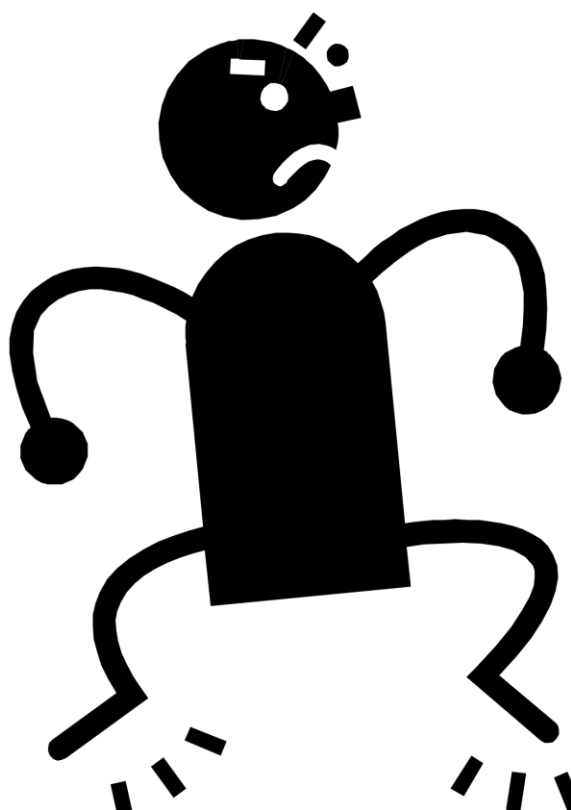
<b>Psychopharmacological Intervention</b>	<ul style="list-style-type: none"> <li>➤ Medical agents including stimulants, typical and atypical antipsychotics, and mood stabilizers</li> <li>➤ Some evidence for the effectiveness of several medications in reducing the symptoms of CD, but the support is far from conclusive</li> <li>➤ Rate of improvement is far higher when paired with psychosocial treatment</li> <li>➤ Benefits of the medication must always be considered in conjunction with the cost of side effects</li> </ul>
<b>Multisystemic Treatment (MST)</b>	<ul style="list-style-type: none"> <li>➤ Considers the family as important but also includes other systems such as peers, school, and neighbourhood</li> <li>➤ Family: employs some form of Family Systems Therapy</li> <li>➤ Peers: interventions attempt to diminish associations with deviant peers and replace those relationships with more positive ones (e.g., facilitating membership in organized athletics, after-school activities)</li> <li>➤ School: strategies to help parents monitor school performance by opening lines of communication between parents and teachers</li> <li>➤ Biological: employs the use of psychopharmacology</li> <li>➤ Broad-based and flexible to deal with the various causal factors associated with CD</li> <li>➤ Time consuming</li> </ul>
<b>Cognitive-Behavioural Treatment (CBT)</b>	<ul style="list-style-type: none"> <li>➤ Focuses primarily on the thought processes</li> <li>➤ Employs behavioural techniques to change the processes that are seen as being responsible for problematic behaviour</li> <li>➤ Provider engages the individual in new ways of thinking that will result in new ways of feeling and behaving</li> <li>➤ Can include teaching of problem-solving skills and relaxation training</li> <li>➤ Moderately effective in treating CD</li> <li>➤ May not consider sufficiently family influences in the development and maintenance of CD</li> </ul>

Adapted from: Austin & Sciarra (2010); Baruch, Vrouva, and Well (2011); Ercan et al. (2011); and Kauffman & Landrum (2013)



## Part Two

# Activities and Resources



(Microsoft Word, version 2010)

## The Acting-Out Cycle: What Can You Do?

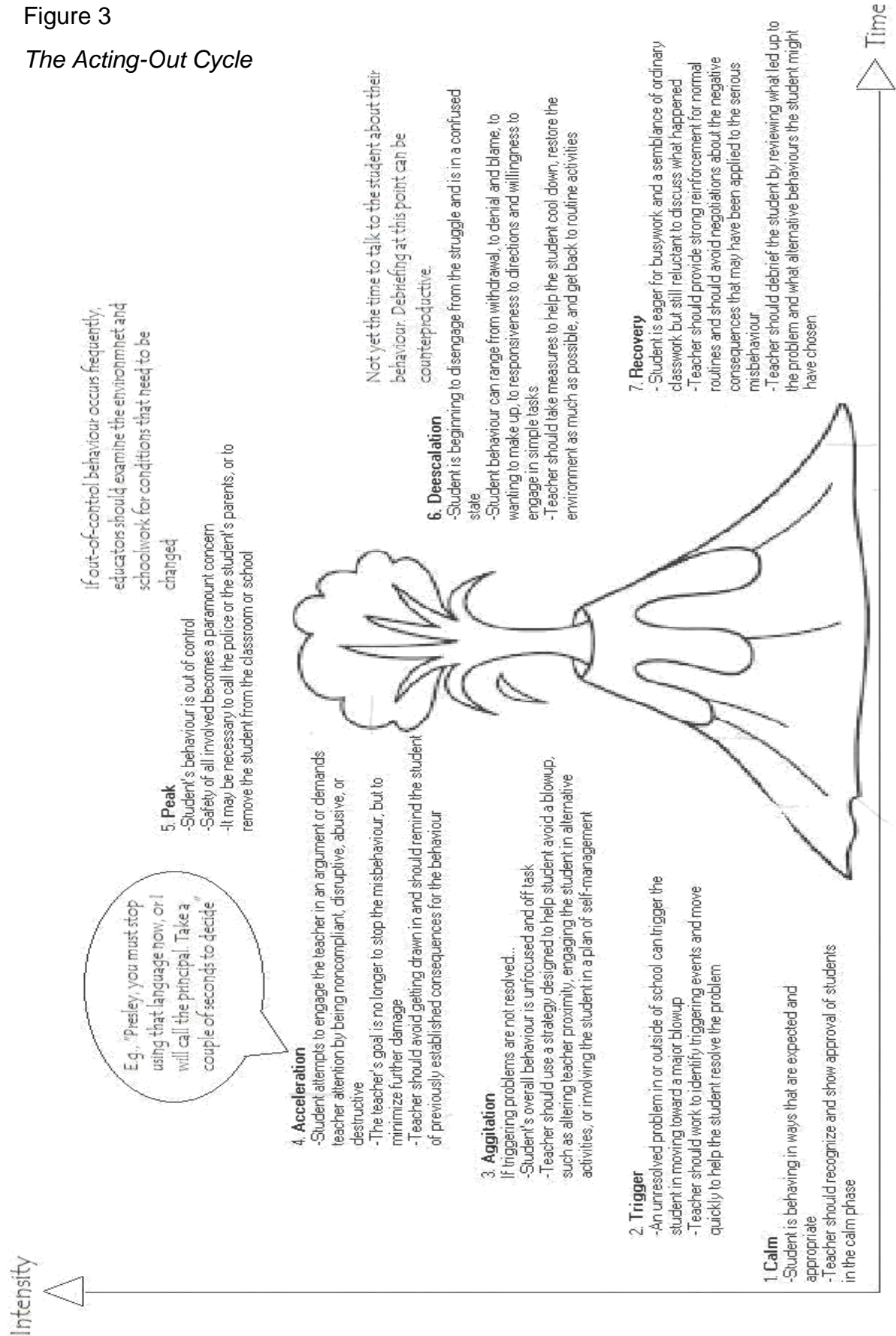
Colvin (1992) presents the acting-out behaviour cycle. The acting-out behaviour cycle can be used by teachers when thinking about intervention.

The cycle begins with the *calm* phase in which the individual's behaviour is appropriate (Kauffman & Landrum, 2013). It is important to acknowledge and show approval of students in the calm phase. Next, an unresolved problem can *trigger* the first stage in moving toward a major blow-up (Kauffman & Landrum, 2013). To avert further escalation, the teacher should move quickly to help the individual resolve the problem. When the problem is not resolved, the individual can move into a state of agitation and will exhibit unfocused and off task behaviour (Kauffman & Landrum, 2013). If there are indications of agitation, the teacher should use strategies to help the student avoid a blow-up, such as altering proximity, engaging the student in an alternative task, or involving the student in a plan of self-management.

Agitation can lead to *acceleration* (Kauffman & Landrum, 2013). During this phase the student engages the teacher in a coercive struggle. The goal is no longer to stop the misbehaviour but to minimize further damage (Kauffman & Landrum, 2013). Prompt and unequivocal follow-through in applying the appropriate consequences is important. In the *peak* phase, the student's behaviour is out of control, and the safety of all concerned becomes a paramount concern (Kauffman & Landrum, 2013). Frequent out of control behaviour indicate a need to examine the environment and schoolwork for conditions that need to be changed.

The *deescalation* phase is when the student begins to disengage from the struggle and is in a confused state (Kauffman & Landrum, 2013). The teacher should take measures to help the student cool down, restore the environment as much as possible, and return to routine activities. Debriefing should not occur at this point and is likely to be counterproductive (Kauffman & Landrum, 2013). Finally, the student enters a recovery phase in which they are eager for busywork but are still reluctant to discuss what happened. Teachers should provide strong reinforcement for normal routines (Kauffman & Landrum, 2013). At this point, it is crucial that the student is debriefed on what led up to the problem and what alternative behaviours the student might have chosen. Figure 3 describes the acting-out cycle.

Figure 3  
The Acting-Out Cycle



## Steps to Prevent or Lessen Antisocial Behaviour

### 1. Provide effective consequences.

- ✓ Nonviolent, immediate consequences that are proportional to the seriousness of the offense
- ✗ Avoid random, harsh, and unfair consequences

### 2. Teach nonaggressive responses.

- ✓ Teach nonaggressive conflict resolution and problem solving

### 3. Stop aggression before it takes root.

- ✓ Intervene early at the first instances of antisocial behaviour

### 4. Restrain and reform public displays of aggression.

- ✓ Reduce the amount of exposure to aggression in the media
- ✓ Discuss the realistic consequences of aggression depicted by the media

### 5. Correct the conditions of everyday life that foster aggression

- ✓ Provide opportunities for supervised recreation or other productive activity during non-school hours
- ✓ Access to social programs that address poverty, unemployment, and related social inequities

### 6. Offer more effective instruction and more attractive educational options.

- ✓ Differentiate the curricula to help more students find options that interest them and prepare them for adulthood

Adapted From: Austin & Sciarra (2010) and Kauffman & Landrum (2013)

## 12 Intervention Techniques for Managing the Acting-Out Student

### 1. Rules

- ✓ Clear and explicit statements defining the teacher's expectations for classroom conduct
- ✓ A few clear rules letting students know how they should behave and what is prohibited
- ✓ Positively stated rules should guide the teacher's praise, approval, and other forms of positive reinforcement
- ✓ Negatively stated rules guide the teacher's use of punishment

### 2. Teacher praise

- ✓ Positive verbal, gestural, or other affective indications of approval
- ✓ For desirable, nonaggressive student conduct

### 3. Positive reinforcement

- ✓ A rewarding consequence
- ✓ Immediately after appropriate behaviour
- ✓ Frequently
- ✓ With enthusiasm
- ✓ With eye contact from the teacher
- ✓ After or with description of the behaviour that earned the reward
- ✓ In ways that build excitement and anticipation for obtaining them
- ✓ In great variety
- ✓ Desirable behaviour should be reinforced; undesirable behaviour should be ignored

### 4. Verbal feedback

- ✓ Provide student with information about the appropriateness or inappropriateness of academic or social behaviour
- ✓ Clear feedback that is primarily positive
- ✓ Avoid arguments
- ✓ Find the most effective pace and timing

### 5. Stimulus change

- ✓ Alter antecedent events or conditions that set the stage for behaviour
- ✓ E.g., make instructions shorter and clearer, present tasks or commands in a different way, modify the classroom environment

### 6. Contingency contract

- ✓ A written performance agreement between a student and teacher that specifies roles, expectations, and consequences

- ✓ Tells the student what they will do (academic and behaviour expectations) and what consequences they will receive (for meeting or for not meeting the expectations)
- ✓ Written with the student's age and intelligence in mind
- ✓ Simple, straightforward statements

#### 7. Modeling plus reinforcing imitation

- ✓ Showing or demonstrating the desired behaviour and providing positive reinforcement for matching responses
- ✓ Teach student whom to watch, what to look for, and what to match
- ✓ Done in private one-on-one sessions with the teacher

#### 8. Shaping

- ✓ Building new responses by beginning with the behaviour the student can already perform at some level and reinforcing successive approximations of the desired behaviour
- ✓ Identify and reinforce small increments of improvement
- ✓ Requires careful attention to the student's current behaviour in relation to a behavioural goal
- ✓ Ignore behaviour that doesn't represent progress toward the goal

#### 9. Systematic social skills training

- ✓ Teaches skills that help students initiate and maintain positive social interactions, develop friendships and social support networks, and cope effectively with the social environment
- ✓ Intensive and systematic
- ✓ Aimed at demonstration and practice of the skills in natural or everyday environments in which they are needed to avoid coercive struggled and aggressive behaviour

#### 10. Self-monitoring and self-control training

- ✓ Consistent tracking, recording, and evaluating of one's own specific behaviours with the intention of changing those behaviours
- ✓ Prompting oneself or applying consequences to oneself
- ✓ Require explicit training and rehearsal
- ✓ Motivate students to use them
- ✗ May not be appropriate for students with serious aggressive behaviour or students who do not have the required cognitive awareness or social maturity

#### 11. Time-out

- ✓ The temporary removal or suspension of a student's opportunity to obtain positive reinforcement based on their display of a specific misbehaviour
- ✓ Generally reserved for serious behavioural problems

## 12. Response cost

- ✓ Removal of a previously earned reward or reinforcement (or portion of one) contingent on a specific misbehaviour
- ✓ Student should have ample opportunities to earn reinforcement
- ✗ Ineffective without a strong program of positive reinforcement

Adapted From: Austin & Sciarra (2010); Evans et al. (2012); Hoff & Ervin (2012); Kauffman & Landrum (2013), Walker (1995)



## **A Six Session Intervention Plan for Conduct Problems in the Mainstream Classroom**

Table 7 outlines a six-session developmental prevention and intervention plan for educators. This plan can be delivered to students at the elementary school level (grades 3-8), including students without CD. The two week plan consists of two anger management sessions, two social skills session, and two social decision making sessions.

Table 7

*The Six- Session Developmental Prevention/ Intervention Plan Overview*

<b>Week</b>	<b>Anger Management/ Thinking Error Correction</b>	<b>Social Skills</b>	<b>Social Decision Making</b>
<b>1</b>	1. Reevaluating, relabeling Anger management, not elimination <ul style="list-style-type: none"> <li>➤ Discuss anger, aggression, and the benefits of controlling anger</li> <li>➤ Identify thinking errors about aggression and violence</li> <li>➤ Relabel anger/ aggression and non-violence</li> </ul>	2. Dealing constructively with negative peer pressure <ul style="list-style-type: none"> <li>➤ Recognize negative peer pressure</li> <li>➤ Thinking ahead to consequences of what the person wants you to do (TOP)</li> <li>➤ Deciding what to do</li> </ul>	3. John's Problem Situation Key values: Relationships and respect <ul style="list-style-type: none"> <li>➤ Value of close friends</li> <li>➤ Understanding the feelings of others</li> <li>➤ Getting even is immature</li> </ul>
<b>2</b>	4. Relaxation techniques for reducing anger <ul style="list-style-type: none"> <li>➤ Acquire/ apply techniques of deep breathing, counting backward, pleasant and peaceful imagery</li> <li>➤ Recognize the benefits of using relaxation techniques in sudden anger situations</li> </ul>	5. Keeping out of fights <ul style="list-style-type: none"> <li>➤ Using relaxation techniques</li> <li>➤ Thinking ahead to consequences of fighting (TOP)</li> <li>➤ Resolving the situation constructively</li> </ul>	6. Stephanie's Problem Situation Key values: Quality of life and truth <ul style="list-style-type: none"> <li>➤ Value of family</li> <li>➤ Understanding the feelings of others</li> </ul>

## Anger Management/ Thinking Error Correction

### Lesson 1: Reevaluating and Relabeling Anger/ Aggression

Adapted from the EQUIP Approach: Teaching Adolescents to Think and Act Responsibly  
(Dibiase, Gibbs, Potter, & Blount, 2012)

#### Objectives:

- Discuss anger, aggression, and the benefits of controlling anger
- Identify thinking errors about aggression and violence
- Relabel anger/ aggression and non-violence

#### Handouts

3-1 The Clown- or Clowns? – In the Ring

#### Procedure and Facilitator Notes

Begin with a discussion of anger and aggression that invites students to step back from anger and see its advantages and disadvantages.

Say something like:



*If you get angry pretty often, it must have some advantages for you. You also may have noticed some disadvantages of letting your anger get out of control.*

During the discussion, point out that anger can be good if it is controlled or managed to motivate constructive behavior. Point out that the goal is to manage or control- not to eliminate- your anger. Aggression may sometimes be justified for legitimate self-defense. Start the relabeling:



*Strong people (individuals who are truly cool) control their anger. Successful athletes are powerful because they use self-control. (Ask for or provide examples). Self- Control makes you a winner, not a wimp. If aggression is your only option, you are the weak or dependent one.*

As the students discuss the advantages and disadvantages of anger/ aggression, list these advantages and disadvantages (or benefits of controlling anger) in separate columns on an easel pad. When the list is completed, you may post it in your room for future reference. Some themes that might arise in the discussion include the following:

Self- Defense	Power	Vengeance
“To protect myself”  “So no one will step on me”  “So others will not take advantage of me”	“Makes me feel big, powerful, superior”  “Then I’m free to get things, do what I want”	“To get even”  “To not let others get away with putting me down or pushing me around”

Look for changes to ask about the thinking errors and sociomoral immaturity in these advantages:

Self- Defense	Power	Vengeance
“I was only defending or protecting myself”  ➤ Can often be an excuse (Minimizing/ Mislabeling) for unprovoked aggression	To hurt others so that you can “do what you want”  ➤ Fails to respect others (Self-Centered)	Hurting others “to get even”  ➤ Reflects a low-level eye-for-an-eye, tooth-for-a-tooth morality.

The longer the students talk about the supposed advantages- especially if you highlight the immaturity or thinking errors- and right-label the out-of-control aggression- the more they may start to mention some disadvantages:

	Instead of...	Disadvantages
<b>Self-Defense</b>	Preventing others from “stepping on you”	Aggression causes more problems, more fights, and makes things worse
<b>Power</b>	Feeling big or powerful	Stupid, embarrassed, or sorry
	Getting a rush	You lose friends because they can’t trust you

	People fearing you	They don't respect you or want to be around you
<b>Vengeance</b>	You getting even	The other person gets angry and could try to get back at you

Display the Clown- or Clowns? – In the Ring diagram (Handout 3-1) in a whole-class format to drive home the relabeling of anger/aggression as weak or foolish.

Explain the following:

The clown in the circus ring is someone who is trying to start a fight.

A: He is a clown and a fool because he is not thinking of all the disadvantages of anger and violence. His goal is to make you a fool, too, to draw you into the circus ring with him.

B: He wants to attach his strings to you. Then he can pull on the strings and draw you into the ring with him.

C: If you let him attach the strings and pull you in, then who is in control? Who is strong? And he wins if you start fighting. How many clowns are there in the ring now?

To apply the example to real life, ask the students:



*Has some clown even succeeded in pulling your strings, pulling you into the ring? What kind of “strings” (e.g., name-calling, challenging you in front of others, making remarks about your family) did you let the person attach to you to pull you into the ring?*

*Have you even been a foolish clown trying to pull someone into the ring with you? What strings did you use to try to make that person into a clown like you?*

You can conclude the discussion by inviting the group to list the four benefits of controlling their anger:

1. You won't hurt anybody.
2. Other people will like and help you.
3. You won't get in trouble.

4. You will feel better about yourself because you will know that you truly are strong (truly strong people can control themselves).

HANDOUT 3-1  
The Clown—or Clowns?—in the Ring

---

**A****B****C**

From *Teaching Adolescents to Think and Act Responsibly: The EQUIP Approach*, © 2012 by A.-M. DiBiase, J.C. Gibbs, G.B. Potter, and M.R. Blount. Champaign, IL: Research Press (800-519-2707; [www.researchpress.com](http://www.researchpress.com)).

## Anger Management/ Thinking Error Correction

### Lesson 2: Relaxation Techniques for Reducing Anger

Created using guiding strategies from The EQUIP Approach: Teaching Adolescents to Think and Act Responsibly (Dibiase, Gibbs, Potter, & Blount, 2012); Singh et al., 2007; Chiasson, 2013)

#### Objectives:

- Review cognitive distortions and problem names from the previous session.
- Acquire and apply techniques of deep breathing, counting backward, and pleasant and peaceful imagery.
- Recognize that the use of relaxation techniques in sudden anger situations can buy crucial time for corrective self-talk and constructive social skills.

#### Procedure and facilitator notes

A key technique in anger management is engaging in activities incompatible with anger. Especially in sudden-anger situations, breathing deeply, counting backward, and invoking peaceful imagery are important because they are simpler and therefore quicker, “buying time” for corrective self-talk and constructive social skills to kick in. Students can prevent anger buildup by starting to take deep breaths, for example, even before beginning to deal with thinking errors.



Say:

*We have learned about corrective self-talk. The techniques we are learning today pertain to relaxation. These techniques are intended to help deal constructively with anger.*

*Relaxation techniques can cut short thinking about an anger-provoking event and can help you keep from becoming angry all over again or thinking about revenge.*

*Sometimes, in hot spots, anger can build so rapidly that by the time you start to correct your thinking errors, it is too late- you may find yourself already engage in violence or aggression.*

1. *If you are standing, stand in a natural rather than aggressive posture.*
2. *If you are sitting, sit comfortably with the soles of your feet flat on the floor.*
3. *Breathe naturally, and do nothing.*
4. *Cast your mind back to an incident that made you very angry. Stay with the anger.*



5. *You are feeling angry, and angry thoughts are flowing through your mind. Let them flow naturally, without restriction. Stay with the anger. Your body may show signs of anger (e.g., rapid breathing).*

Discuss some of the signs that our bodies may show when we are angry.

### **Breathing Deeply**

Show the value of the first technique- slow, deep breathing- by describing and enacting the example of the basketball player who has just been fouled by an opponent:



*The basketball player is angry at being fouled, and he's nervous because the attention is on him and he needs to make this shot for the team. But he knows he will not make it if he stays angry and nervous. He is at the free-throw line. What does he do? (Discuss)*

*He probably tries to think calming thoughts, but he also tries to calm down by breathing deeply and slowly a few times. You can see him taking those slow, deep breaths. He knows from experience that's one of the best ways to get back in control of the situation. As soon as he starts taking a few slow, deep breaths, he will feel less angry and nervous- and will have a better chance of making that shot- or, in the situation you're in, doing something responsible rather than destructive.*

*Now remember to make sure your breathing is slow and deep. "Slow" means that taking in the breath should take 5 or 6 seconds. Hold the breath for a few seconds. Then slowly breathe out, again taking 5 or 6 seconds. Wait a few seconds, and then breathe slowly in and out again. It should be a slow rhythm. "Deep" means that your lungs should be full. You will know your lungs are full enough if they are putting some pressure down on the top of your stomach. You should be able to feel that downward pressure.*

*Okay, let's give it a try. Let's imagine some activating event. What are some things, again, that put you in a hot spot? (Discuss and write examples on the easel pad.)*

*Imagine that is happening, whatever it is for you. Now start slow, deep breathing. (Model deep breathing)*

*Could you feel that helping? (Discuss briefly)*

## Counting Backward



Explain how counting backward can prevent a dangerous buildup of anger:

*There are two more things that can come in handy. Another effective relaxation technique is counting backward. You silently count backward (at an even pace) from 20 to 1 when you feel that anger coming on. Sometimes you can just turn away from the hot spot while you are counting. You can count backwards as you are breathing deeply. You should use these techniques together to get as much power as you can for regaining control.*

## Counting backward Plus Slow, Deep Breathing



The next approach combines the two techniques taught previously:

*So let's try both of these techniques together. Okay, imagine that worst event.* (Allow 10 to 15 seconds)

*Now get the deep breathing started.* (Model and make sure the students are breathing deeply)

*Now we will count aloud from 20. Now start.* (Model; start counting backward; make sure students are breathing deeply and counting)

*Could you feel that helping?* (Discuss)

*Of course, when you are using this technique, you will be counting silently.* (Lead the students in deep breathing; remind them that they should be counting backward silently)

## Invoking Pleasant or Peaceful Imagery

In addition to deep breathing and counting backward, pleasant or peaceful imagery will help students calm down:



*The third technique you can use is to imagine pleasant or peaceful scenes. You can calm yourself down from angry mind activity by imaging a pleasant or peaceful scene. This is a lot like calming self-talk, except that we are talking about mental pictures instead of thoughts. What are some happy or peaceful scenes that you can imagine?* (Through discussion, make a list)

## All Three Techniques Together

Once students become proficient at these techniques, they can practice using all three at once:



*Let's see if we can use all three techniques at once. First, think of the activating event that tends to start off the anger-causing self-talk. (Allow 10 to 15 seconds)*

*Now let's start slow, deep breathing. (Model and make sure students are breathing deeply)*

*Now start counting backward from 20, silently. (Allow 10 to 15 seconds)*

*Now imagine your favorite peaceful scene while breathing deeply and counting backward. (Allow 10 to 15 seconds)*

*Could you feel that helping? (Discuss)*

*These three techniques- slow, deep breathing; counting backward; and pleasant or peaceful imagery- will help you reduce those angry body reactions. If you can, use these three things together for maximum anger-control power. They will buy you crucial seconds. Then you can start to think straight. You can reduce your anger even more with calming self-talk that corrects your thinking errors.*

Encourage students to try these techniques outside the class.

## Social Skills

### Lesson 1: Dealing Constructively with Negative Peer Pressure

Adapted from the EQUIP Approach: Teaching Adolescents to Think and Act Responsibly  
(Dibiase, Gibbs, Potter, & Blount, 2012)

#### Objectives:

- Recognize negative peer pressure
- Thinking ahead to consequences of what the person wants you to do (TOP)
- Deciding what to do



*Ask the students to describe a pertinent situation, or use one of the suggested situations.*

*Have the students start role-playing the situation. After negative pressure has been established, have the observer in each triad freeze the role-play for Steps 1 and 2.*

#### Step 1: Think, “Why?”

- Think about why the other person is saying.
- What is it the person wants you to do? Why does the person want you to do it?

#### Step 2: Think Ahead

- Think about the consequences if you do what the person wants you to do. Who might get hurt?
- How might you feel if you go along?
- How should you feel if you go along?

Note the use in Step 2 of thinking ahead to consequences (TOP)

Prepare to resume the role-play.

#### Step 3: Decide What You Should Do

- What reasons will you give the person?
- What will you suggest to do instead?

Instruct students, after they have prepared, to continue the role-play.

#### **Step 4: Tell What You Decided**

- In a calm, straightforward way, tell the person what you have decided.
- Give a good reason—for example, how the pressure makes you feel or who might get hurt if you do what the person wants.

If more than one person is involved in the negative pressure, encourage students to tell their decisions to one person in the group. Giving a good reason for not going along may help the members of the group rethink what they should do.

#### **Step 5: Suggest Something Else to Do**

- This should be something still enjoyable, but responsible.

#### **Suggested Situations for Using This Skill**

1. A peer is teasing someone or planning to take something that belongs to someone else, and they want you to join in.
2. A group of peers is planning to vandalize a neighborhood and want you to come along.
3. Some of your friends decide not to go back to school after lunch, and they want you to come along with them.
4. A group of peers asks you to join them in giving the substitute teacher a difficult time.

#### **Facilitator Notes**

Indicate to students that this social skill is a crucial tool in helping them avoid an Easily Misled problem. It is also important to stress that blaming irresponsible behavior on negative peer pressure involves a Blaming Others thinking error.

## Social Skills

### Lesson 2: Keeping Out of Fights

Created using guiding strategies from The EQUIP Approach: Teaching Adolescents to Think and Act Responsibly (Dibiase, Gibbs, Potter, & Blount, 2012; Chiasson, 2013)

Objectives:

- Using relaxation techniques
- Thinking ahead to consequences of fighting (TOP)
- Resolving the situation constructively

#### Step 1: Stop and think about why you want to fight



*Tell students that, if they need to, they can breathe deeply, count backward, or think calming thoughts to calm down. They can also consider whether they did anything to contribute to the problem.*

#### Step 2: Think ahead



*Ask yourself, "If I fight, then what will be the consequences?"*

Encourage students to remember to think about consequences for others (TOP), including people who are not on the scene but who will be affected later on: How will they feel? What will they do? How will you feel? What are the likely consequences later on for you?

Note the use in Step 2 of thinking ahead to consequences (TOP)

#### Step 3: Think of a Way to Handle the Situation Besides Fighting and Do It.

Students will need a partner for this step.

Should you...

- Walk away for now?
- Give a displeased look?
- Talk to the person in a calm and friendly way?
- Ask someone for help in solving the problem?



*Ask triad members: “Is the other person calm enough or reasonable enough to talk to?” “Are you calm enough yet to talk?”*

Have members discuss some of the signs that help them to recognize when:

1. The other person is calm enough or reasonable enough to talk to. What does this sound like? Look like?
2. You are calm enough to talk. What does this sound like? Look like? Feel like?



*“Who might help you resolve the situation constructively (teacher, parent, or guardian, friend)?”*

Point out that in some situations, such as self-defense or the defense of some other victim, you may have no choice but to fight.

Invite members to share some of the reasons for fighting. As a group, discuss whether fighting was the only choice in that situation, or if they could have resolved the situation constructively.

### **Suggested Situations for Using This Skill**

1. A peer has just come up to you and demanded you give him your cell phone.
2. You just found out who stole your running shoes.
3. A peer starts teasing you and calling you names
4. You lost your privilege to play on the school basketball team because someone told your teacher you spray painted on the outside of the school building, and you just found out who told on you.
5. A peer grabs your lunch and tosses it in the garbage.
6. In the baseball game, you have just come up to bat. The other team's pitcher yells that you can't hit the ball and calls you a loser.

### **Facilitator Notes**

If an occasion does not arise for practicing the skill, students may be given the option of completing the Social Skills Practice Sheet (Handout 4-1) with information from a past incident.

**HANDOUT 4-1**  
**Social Skills Practice Sheet**

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Student: \_\_\_\_\_ Date: \_\_\_\_\_

**Practice Assignment**

*Skill:* \_\_\_\_\_

**If Applicable**

*Use with whom?* \_\_\_\_\_

*Use when?* \_\_\_\_\_

*Use where?* \_\_\_\_\_

*Describe what happened when you did the practice assignment. For example, did you skip any steps? What was the other person's reaction?*

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*Rate yourself on how well you used the skill (check one).*

☐ Excellent    ☐ Good    ☐ Fair    ☐ Poor



## Social Decision Making

### Lesson 1: John's Problem Situation

Created using guiding strategies from the EQUIP Approach: Teaching Adolescents to Think and Act Responsibly (Dibiase, Gibbs, Potter, & Blount, 2012; Chiasson, 2013)

Key values: Relationships and Respect

- Value of close friends
- Understanding the feelings of others
- Getting even is immature

John and Jordan are always getting in trouble together at school. Last week, while walking back to school during lunch, they were attacked by two boys from another school. Jordan is usually a hothead- sure enough he wants to get even by going to the other boys' school and fighting them after school. John tells Jordan to chill and calm down- that if they go back to school and tell their teachers, their attackers will be held accountable. The next morning, John and Jordan are called down to the office. John is sure it has something to do with what Jordan did after school.

#### What should John say or do?

1. Should John confront Jordan about what he did after school? (Check one)
  - ☐ Yes, should confront
  - ☐ No, should mind his own business
  - ☐ Can't decide
2. Should John tell his principal what he knows? (Check one)
  - ☐ Yes, should tell
  - ☐ No, should keep quiet
  - ☐ Can't decide
3. What if Jordan tells John that "those boys got what they deserved" and warns John to mind his own business? Then should John tell the authorities what he knows? (Check one)
  - ☐ Yes, should tell
  - ☐ No, should keep quiet
  - ☐ Can't decide

4. What if Jordan reminds John that he is supposed to be his best friend? Then should John tell the principal what he knows? (Check one)
  - Yes, should tell
  - No, should keep quiet
  - Can't decide
5. Is it ever right to tell on someone? (Check one)
  - Sometimes right
  - Never right
  - Can't decide

### **Facilitator Notes**

The problem situation is intended for more seriously at-risk students. The problem situation can be altered for more mainstream student groups.

John's Problem Situation raises issues relating to gang behaviors, intimidation, and loyalty, both to a friend and to groups. The mature moral position is that John will confront Jordan about the retaliation on the other boys and will tell the principal what he knows, even if he is threatened and intimidated by Jordan. In confronting Jordan, John will find it helpful to use the skill Dealing Constructively with Someone Angry at You.

### **Discussion**

#### **Phase 1: Introduce the Problem Situation**

Give group members the problem situation handouts they completed earlier. Ask for a volunteer to read the problem situation aloud, and then ask the group:

- Who can tell the group what John's problem is?
- Why is that a problem?
- Do problems like this happen?
- Has anyone had a problem like this?

Keep the discussion brief. Once the group understands the problem situation and accepts it as relevant, transition to the next phase.

#### **Phase 2: Cultivate Mature Morality**

- Refer the group to the decision chart and explain that it shows the answers everyone gave previously to the questions about the situation.

- Call on students who chose the responsible decisions to share their reasons for answering the way they did. On the easel pad, write down students' reasons for making the responsible decisions.
- Stimulate discussion first among those group members likely to give mature reasons for their responsible decisions.
- Give less attention to group members who, although they selected the responsible decisions, are less likely to support them with mature reasons.



Before moving to Phase 3, summarize mature reasons by saying something like “We have a number of good reasons here. For example, the group said (indicate the most mature reasons).”

### **Phase 3: Remediate Moral Development Delay**

- Bring into the discussion group members who selected the irresponsible decisions.
- On the easel pad, write down group members' reasons for making the irresponsible decisions.
- Encourage the more-mature responders to defend their mature moral positions against the less-mature suggestions. Ask open-ended questions and provide prompts as necessary to further discussion.
- Finally, call on participants who “can’t decide” to discussion their responses.

### **Phase 4: Consolidate Mature Morality**

- Ask if anyone would object to declaring a positive majority decision as the group's official decision. Either you or a responsible group member may circle/ underline the majority decision.
- Continue discussion, attempting to convert as many of the positive majority decisions into official, even unanimous, group decisions.
- Referring to the reasons listed on the easel pad; orient the group to their most mature reasons for their responsible decisions. Ask the group if those reasons should be chosen as the group's official “best” reasons. Either you or a responsible group member may circle/ underline the reasons.

## Social Decision Making

### Lesson 2: Stephanie's Problem

Adapted from the EQUIP Approach: Teaching Adolescents to Think and Act Responsibly  
(Dibiase, Gibbs, Potter, & Blount, 2012)

Key Values: Quality of Life and Truth

- Value of family
- Understanding the feelings of others

"Your father is late again", Stephanie's mother tells Stephanie one night as she sits down to dinner. Stephanie knows why. She passed her father's car on the way home from school. It was parked outside the bar. Stephanie's mother and father have argued many time about her father's stopping off at a bar on his way home from work. After their last argument, her father promised he would never do it again. "I wonder why your father is late," Stephanie's mother says. "Do you think I should trust what he said about not drinking anymore? Do you think he stopped off at the bar again?"

#### What should Stephanie say or do?

1. Should Stephanie cover for her father by lying to her mother? (Check one)
  - ☐ Yes, should cover
  - ☐ No, should tell
  - ☐ Can't decide the truth
2. Was it right for Stephanie's mother to put Stephanie on the spot by asking her a question about her father? (Check one)
  - ☐ Yes, right
  - ☐ No, wrong
  - ☐ Can't decide
3. What if Stephanie's father drinks a lot when he stops at the bar and then comes home and yells at Stephanie's mother- and maybe even Stephanie? Then what should Stephanie do? (Check one)
  - ☐ Should cover for home
  - ☐ Should tell the truth
  - ☐ Can't decide

4. Which is most important for Stephanie's decision? (Check one)
  - ☐ What's best for herself
  - ☐ What's best for her mother
  - ☐ What's best for her dad
  - ☐ What's best for the family
5. In general, how important is it to tell the truth? (Check one)
  - ☐ Very important
  - ☐ Important
  - ☐ Not important

### **Facilitator Notes**

The problem situation is intended for more seriously at-risk students. The problem situation can be altered for more mainstream student groups.

### **Overview**

Stephanie's Problem Situation concerns parental rather than peer pressure. Furthermore, whereas in peer situations the peer frequently has a negative or irresponsible aim, in Stephanie's Problem Situation the mother is at least well intentioned in her questions about the father.

This situation is problematic for students until Question 3 ("What if Stephanie's father drinks a lot when he stops at the bar and then comes home and yells at Stephanie's mothers- and maybe even Stephanie?"). Students here might indicate that Stephanie should tell her mother what she knows, in the interest of what is best for the family (See also Question 4). These questions plus Question 5 (concerning the importance of telling the truth) offer the best opportunities for cultivating the consolidating mature morality. Reasons for the importance of telling the truth can be surprisingly mature (e.g., You wouldn't want someone to lie to you because their word then means nothing, and society is based on truth and trust)

Dissenters might suggest that it was wrong for Stephanie's mother to put Stephanie on the spot (Question 2) and that getting Stephanie involved is too heavy to burden to place on a child- Stephanie would feel guilty if her disclosure resulted in a divorce. They may suggest that Stephanie could help in a limited way but having a private talk with her dad. Pragmatically, however, if Stephanie tells her mother (Question 1), her dad may become very angry with her.

A group that has grown in trust and cohesiveness can discuss this problem situation even though it may strike close to home.

## Discussion

### Phase 1: Introduce the Problem Situation

Give group members the problem situation handouts they completed earlier. Ask for a volunteer to read the problem situation aloud and then ask the group

- Who can tell the group what Stephanie's problem is?
- Why is that a problem?
- Do problems like this happen?
- Has anyone had a problem like this?

Keep the discussion brief. Once the group understands the problem situation and accepts it as relevant, transition to the next phase.

### Phase 2: Cultivate Mature Morality

- Refer the group to the decision chart and explain that it shows the answers everyone gave previously to the questions about the situation.
- Call on students who chose the responsible decisions to share their reasons for answering the way they did. On the easel pad, write down students' reasons for making the responsible decisions.
- Stimulate discussion first among those group members likely to give mature reasons for their responsible decisions.
- Give less attention to group members who, although they selected the responsible decisions, are less likely to support them with mature reasons.



Before moving to Phase 3, summarize mature reasons by saying something like "We have a number of good reasons here. For example, the group said (indicate the most mature reasons)."

### Phase 3: Remediate Moral Development Delay

- Bring into the discussion group members who selected the irresponsible decisions.
- On the easel pad, write down group members' reasons for making the irresponsible decisions.
- Encourage the more-mature responders to defend their mature moral positions against the less-mature suggestions. Ask for open-ended questions and provide prompts necessary to further discussion.
- Finally, call on participants who "can't decide" to discuss their responses.

**Phase 4: Consolidate Mature Morality**

- Ask if anyone would object to declaring a positive majority decision as the group's official decision. Either you or a responsible group member may circle/ underline the majority decision.
- Continue discussion, attempting to convert as many of the positive majority decisions into official, even unanimous, group decisions.
- Referring to the reasons listed on the easel pad, orient the group to their most mature reasons for their responsible decisions. Ask the group if those reasons should be chosen as the group's official "best" reasons. Either you or a responsible group member may circle/ underline the reasons

## Assessment of the Six- Session Prevention/ Intervention Plan

Students Name:	
Date:	
<b>Anger Management/ Thinking Error Correction</b>	
<input type="radio"/> Identifies thinking errors about aggression and violence	Comments:
<input type="radio"/> Recognizes the benefits of controlling anger	
<input type="radio"/> Applies technique of deep breathing, counting backward, and pleasant peaceful imagery	
<input type="radio"/> Recognizes the benefits of using relaxation techniques in sudden anger situations	
<b>Social Skills</b>	
<input type="radio"/> Identifies negative peer pressures and its consequences	Comments:
<input type="radio"/> Applies Thinking Ahead to Consequences (TOP)	
<input type="radio"/> Able to resolve problem situations constructively	
<b>Social Decision Making</b>	
<input type="radio"/> Can identify the problem situation	Comments:
<input type="radio"/> Able to understand the feelings of others	
<input type="radio"/> Evaluates the value of friendship and family	
<input type="radio"/> Demonstrates ability to relate problem situations to real-life experiences in order to generate critical thinking	



## **Resources and Programs Available for Conduct Disorder**

Table 8 is a list of accessible community programs or agencies pertaining to individuals with Conduct Disorder and associated symptoms in the Niagara Region.

Table 8  
*List of Community Programs or Agencies for Individuals with Conduct Disorder*





Type of Service	Name of Program or Agency	Contact Information
<b>Counselling and Therapy</b>	<p><i>Francophone Community Health Center</i>            Counseling, medical, and immigration services            Ages served: All ages            Languages offered: French            Fees:  None            Area Served: Hamilton and Niagara Regions</p>	810 East Main Street Welland, Ontario 905-734-1141 1-866-885-5947 (Toll Free)
	<p><i>Niagara Health System (NHS)</i>            Inpatient and outpatient mental health services and ambulatory care programs provided            Ages served: All ages            Languages offered: English            Fees:  None            Area Served: Niagara Region</p>	<a href="http://www.niagarahealth.on.ca/">www.niagarahealth.on.ca/</a>
	<p><i>Pathstone Mental Health</i></p> <ul style="list-style-type: none"> <li>Provides various mental health services for children and youth.</li> </ul> <p>Ages served: Up to 18 years            Languages offered: English, French            Fees:  None            Area Served: Niagara Region</p>	3340 Schmon Parkway Thorold, Ontario 905-688-6850 905-684-3407 (Toll Free) 1-800-263-4944 (Crisis Line) <a href="http://www.pathstonementalhealth.ca">www.pathstonementalhealth.ca</a>
<b>Community-Based Services</b>	<p><i>The Canadian Mental Health Association (CMHA) Niagara Branch</i>            A nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness.            Ages served: 16 and up            Language offered: English, French            Fees:  None            Area Served: Niagara Region</p>	905-641-5222 <a href="http://www.cmhaniagara.ca">www.cmhaniagara.ca</a> <a href="mailto:info@cmhaniagara.ca">info@cmhaniagara.ca</a>

Table 8 Continues

Type of Service	Name of Program or Agency	Contact Information
	<p><i>Family and Child Services Niagara</i></p> <ul style="list-style-type: none"> <li>➤ Offers a wide array of services from community programs such as child care, resource consultants, Ontario Early Years Centres and counselling</li> <li>➤ Provides services that protect children at risk of abuse and neglect, and support families in providing the best care possible for their children.</li> </ul> <p>Ages served: All            Languages offered: English            Fees: 🚫 None            Area served: Niagara Region</p>	<p>905-937-7731            1-888-937-7731 (Toll Free)  <a href="http://www.facsniagara.on.ca">www.facsniagara.on.ca</a></p>
	<p><i>Mutual Support Systems of the Niagara Region</i></p> <ul style="list-style-type: none"> <li>➤ Residential care and treatment program for children with emotional and/or behavioural problems.</li> </ul> <p>Ages served: 7 - 18 years            Languages offered: English            Fees: 💰 Yes            Area Served: Niagara Region</p>	<p>792 Canboro Rd            Fenwick, Ontario            905-892-4332  <a href="http://www.mutualsupport.net">www.mutualsupport.net</a></p>
	<p><i>Niagara Supportive Living (NSL)</i></p> <ul style="list-style-type: none"> <li>➤ Focused on housing and caring for individuals with physical, mental, or emotional impairments</li> </ul> <p>Ages served: 22 years and up            Languages offered: English            Fees: 💰 Yes            Area Served: Niagara Region</p>	<p>215 Broadway Avenue,            Welland, Ontario            905-714-9517  <a href="http://www.supportiveliving.ca">www.supportiveliving.ca</a></p>

Table 8 Continues

Type of Service	Name of Program or Agency	Contact Information
<b>Information and Phone Lines</b>	<p><i>Contact Niagara</i></p> <ul style="list-style-type: none"> <li>➤ Identifies appropriate local resources for children who experience emotional and behavioural difficulties, and children who have developmental disabilities.</li> </ul> <p>Ages served: All            Languages offered: English, French            Fees: 🚫 None            Area served: Niagara Region</p>	<p>905-684-3407            1-800-933-3617 (Toll Free)  <a href="mailto:info@contactniagara.org">info@contactniagara.org</a>  <a href="http://www.contactniagara.org">www.contactniagara.org</a></p>
	<p><i>Crisis Outreach and Support Team (COAST)</i></p> <ul style="list-style-type: none"> <li>➤ Provides crisis intervention services to individuals experiencing a mental health crisis. Service is available 24 hours a day, 7 days a week, 365 days a year.</li> </ul> <p>Ages served: All            Languages offered: English            Fees: 🚫 None            Areas served: Niagara Region            * No Health Insurance Number or diagnostic criteria required.</p>	<p>1-800-263-4944 (Toll Free)</p>
	<p><i>The Distress Centre of Niagara</i></p> <ul style="list-style-type: none"> <li>➤ A 24-hour confidential telephone crisis intervention support service</li> </ul> <p>Ages served: All            Languages offered: English            Fees: 🚫 None            Areas served: Niagara Regional Municipality</p>	<p>St. Catharines, Niagara Falls and Area:            905-688-3711            Port Colborne, Wainfleet and Area:            905-734-1212            Fort Erie and Area:            905-382-068            Grimsby, West Lincoln:            905-563-6674  <a href="http://www.distresscentreniagara.com">www.distresscentreniagara.com</a>  <a href="mailto:info@distresscentreniagara.com">info@distresscentreniagara.com</a></p>






Type of Service	Name of Program or Agency	Contact Information
	<p><i>Mental Health Helpline</i></p> <ul style="list-style-type: none"> <li>➤ Provides information about mental health services 24 hours a day, 7 days a week.</li> </ul> <p>Ages served: All            Languages offered: English, French            * Translation service provided for over 170 languages including Mandarin, Spanish, Portuguese, Italian, Vietnamese, Greek, Polish, Russian, and Serbian.</p> <p>Fees:  None            Areas served: Ontario</p>	<p>1-866-531-2600 (Toll Free)  <a href="http://www.mentalhealthhelpline.ca">www.mentalhealthhelpline.ca</a></p>
	<p><i>Strongest Families Institute</i></p> <ul style="list-style-type: none"> <li>➤ Provides mental health treatment via telephone and internet for families, as opposed to face-to-face visits in a clinic</li> </ul> <p>Ages served: 3 - 16 years            Languages offered: English</p> <p>Fees:  None            Area Served: Canada</p>	<p>1-866-470-7111  <a href="http://www.strongestfamilies.com">www.strongestfamilies.com</a></p>
	<p><i>Kids' Help Phone</i></p> <ul style="list-style-type: none"> <li>➤ An anonymous and confidential phone and on-line professional counselling service for youth. Big or small concerns, 24 hours a day, 7 days a week, 365 days a year.</li> </ul> <p>Ages served: 5- 20            Languages offered: English, French</p> <p>Fees:  None            Areas served: Canada</p>	<p>1-800-668-6868 (Toll Free)  <a href="http://www.kidshelpphone.ca">www.kidshelpphone.ca</a></p>

Table 8 Continues

Type of Service	Name of Program or Agency	Contact Information
<b>Emergency and Crisis Services</b>	<p><i>Niagara Health System Crisis</i></p> <p>➤ A 24-hour accessible Community Crisis Care Service is available at each location.</p> <p>Ages served: All</p> <p>Languages offered: English, French</p> <p>Fees: 💰 Yes</p> <p>Area served: Niagara Region</p>	<p>Greater Niagara General Site: 905-378-4647 ext. 54919</p> <p>St. Catharines General Site: 905-378-4647 ext. 43230</p> <p>Welland Hospital Site: 905-378-4647 ext. 33407</p> <p><a href="http://www.niagarahealth.on.ca/services/mental-health">www.niagarahealth.on.ca/services/mental-health</a></p>
<b>Addiction Services</b>	<p><i>Community Addiction Services of Niagara</i></p> <p>➤ Provides access to relevant treatment resources for individuals and their families with alcohol and drug concerns.</p> <p>Ages served: All</p> <p>Languages offered: English</p> <p>Fees: 🚫 None</p> <p>Areas served: Niagara Region</p>	<p>905-684-1183</p> <p><a href="http://www.cas-n.ca">www.cas-n.ca</a></p>
<b>Child and Youth Services</b>	<p><i>Child Advocacy Centre of Niagara</i></p> <p>➤ Provides services to children who have been abused</p> <p>Ages served: Up to and including 15</p> <p>Languages offered: English</p> <p>Fees: 🚫 None</p> <p>Areas served: Niagara Region</p>	<p>8 Forster St, St. Catharines, Ontario 905-937-5435</p>
	<p><i>The Mental Health Project for Youth (TMHP)</i></p> <p>➤ Provides peer support and connects youth with resources in their community.</p> <p>Ages served: 12 - 21 years</p> <p>Languages offered: English</p> <p>Fees: 🚫 None</p> <p>Area Served: Ontario</p>	<p>1-800-652-0394 (Toll Free)</p> <p><a href="http://www.tmhpforyouth.org">www.tmhpforyouth.org</a></p>

Table 8 Continues

Type of Service	Name of Program or Agency	Contact Information
	<p><i>Nightlight Youth Services</i></p> <ul style="list-style-type: none"> <li>➤ Offers residential programs for youth which provide a safe, supervised, and supportive environment.</li> </ul> <p>Ages served: 16-30            Languages offered:            Fees:  None            Area served: Niagara Regional Municipality</p>	<p>5519 Ontario Avenue            Niagara Falls, Ontario            905-358-3678            Fax: 905-358-3678  <a href="http://www.boysandgirlsclubniagara.org">www.boysandgirlsclubniagara.org</a></p>
	<p><i>The RAFT</i></p> <ul style="list-style-type: none"> <li>➤ Providing at-risk youth, families, and neighbourhoods emotional support, crisis intervention, emergency shelter, and referrals.</li> </ul> <p>Ages served: All            Languages offered: English            Fees:  None            Area served: Niagara Regional Municipality</p>	<p>17 Centre St,            St. Catharines, Ontario            905-984-4365</p>
<b>Websites</b>	<p>For adolescents-            Resources designed to reduce the stigma associated with mental illness and increase access to community support</p>	<p><a href="http://www.mindyourmind.ca">www.mindyourmind.ca</a></p>
	<p>Information, resources, and tools that can be applied across disciplines to enhance the understanding of mental health and mental disorders.</p>	<p><a href="http://www.teenmentalhealth.org">www.teenmentalhealth.org</a></p>
	<p>Designed for youth by youth-            Information and resources aimed at reducing the stigma associated with mental illness.</p>	<p><a href="http://www.jack.org">www.jack.org</a></p>
	<p>Information and advice on health, behaviour, and development.</p>	<p><a href="http://www.kidshealth.org">www.kidshealth.org</a></p>

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### Summary of the Chapter

*Conduct Disorder: A Handbook for Elementary School Educators* was created based on the results of the needs assessment questionnaire, theoretical and empirical research on conduct disorder and associated emotional behavioural disorders, and current educational resources.

Chapter Four presented a copy of the conduct disorder handbook, with included a rationale for, objectives of, and instructions on the use of the handbook. The framework of the conduct disorder handbook was based on establishing the background information that would 1) assist educators in developing a better understanding of conduct disorder and aggression; 2) provide educators with strategies and skills that can be used in the classroom to help students develop healthy social and academic skills; and 3) provide educators with a list of resources and agencies that can be shared with both parents and students.

The first section of the handbook focused on developing an understanding of conduct disorder and aggression. The succeeding section of the handbook was an outline of suggested strategies and activities to implement with students exhibiting conduct problems. Finally, a list of community resources and programs is provided. Educators, related service providers, and the child all play an important role in designing and implementing effective interventions. Therefore, it is imperative to provide educators with the information necessary to begin this emerging collaborative process.

## **CHAPTER FIVE: SUMMARY, EVALUATION, IMPLICATIONS, AND RECOMMENDATIONS**

CD is associated with severe functional impairment and is important to treat for several reasons. The DSM-IV-TR highlights the poor outcomes for children who exhibit behaviour challenges at an early age (Ercan et al., 2011). The symptoms of CD can lead to academic difficulties and poor social development and mental health outcomes (Ercan et al., 2011). There is also a risk of physical injuries that may be life-threatening for the child with CD and their victims. Interventions to prevent chronic CD are most effective if they are applied early in life (Ercan et al., 2011). The creation and development of a handbook, *Conduct Disorder: A Handbook for Elementary School Educators* was primarily due to the examination of the behavioural, social, and emotional issues pertaining to conduct disorder and the literature on aggression. It is hoped that the handbook may enrich and augment educator's knowledge, so that they can be equipped with strategies that they can employ with reasonable effectiveness and immediacy. In this chapter, the importance of developing a conduct disorder handbook is outlined, feedback from the evaluation questionnaire is presented, implications of theory and practice are discussed, suggestions for future research are given, and a conclusion is provided.

### **Summary of the Study**

The present project explored conduct disorder and aggression in the context of an educational setting, primarily in an elementary school. When children exhibit aggressive antisocial behaviour and academic failure in the early years, the prognosis is grim, unless effective early intervention is provided. (Kauffman & Landrum, 2013).

Therefore, collaboration between key stakeholders in the provision of services for students who have CD is crucial. The purpose of this project was two-fold: 1) to explore the literature on conduct disorder and aggression to gain a deeper understanding of causal factors and interventions; and 2) to develop a psycho-education handbook for elementary school educators that provides the background information of conduct disorder among children and youth, as well as practical strategies and activities to implement within mainstream classrooms with affected students. This can improve the typical school experience and adverse outcomes associated with conduct disorder.

The theoretical foundation for this project primarily consists of Bandura's (1978) social learning theory, which allowed for a deeper understanding of the causal factors attributed to the development of conduct disorder and aggressive behaviour in children and youth, and how it could be better handled in schools. The specific areas of focus were improving the teacher and student relationship, student self-esteem, and academic achievement.

After examining current empirical research studies on pharmacological and parent-training interventions, there is beneficial evidence that can help to improve symptoms of CD in children and youth (Ercan et al., 2011; Hagen et al., 2011; Padhy et al., 2011; Baruch et al., 2011). However, there is not a single cause of CD and its related problems (Kauffman & Landrum, 2013). Child factors, parenting or family factors, and school-related factors can all contribute to the development of CD. The more factors a child is exposed to, the greater the risk (Kauffman & Landrum, 2013). Treatments should include multidisciplinary interventions because of the frequent co-occurrence of risk

factors in the development of CD (Ercan et al., 2011).

The literature review conducted on conduct disorder among children and youth revealed three common themes: 1) the large prevalence of CD among adolescents (Ercan et al., 2011; Kauffman & Landrum, 2013); 2) the adverse outcomes for children and adolescents diagnosed with CD (Ercan et al., 2011; Kauffman & Landrum, 2013; Singh et al., 2007; Evan et al., 2012); and 3) a lack of interventions adolescents with CD in mainstream classrooms (Kauffman & Landrum, 2013; Evans et al., 2012). A needs assessment was then created to determine the requirements for a resource relating to conduct disorder. The findings from the needs assessment suggested that there was a lack of background knowledge of the characteristics of conduct disorder and interventions strategies. All three participants reported not feeling adequately prepared to teach students with conduct disorder in mainstream classrooms.

The present project's conduct disorder handbook, targeted at elementary school educators was based on the followings: 1) a comprehensive review of the empirical research on conduct disorder and aggression and; 2) findings from the needs assessment.

*Conduct Disorder: A Handbook for Elementary School Educators* was developed

following the specific objectives listed below:

1. Educators will be able to identify the behavioural, cognitive, and social characteristics of CD.
2. Educators will be able to conceptualize the epidemiology (i.e. Prevalence, identification, and diagnosis) of CD.

3. Educators will recognize the intervention and treatment plans available for students with CD.
4. Educators will evaluate the handbook for practicality, efficiency, and relevance as it will be implemented into the curriculum.

### **Evaluation of the Handbook**

Conduct Disorder: A Handbook for Elementary School Educators was reviewed by the same sample of educators who completed the needs assessment. A summary of the three participants' demographic information is provided in Table Three.

#### *Duration of the Evaluation Process*

The evaluative questionnaire (Appendix B) consisted of semi-structured questionnaire comprised of seven questions. Each question focused on a particular area of the handbook. Space was also provided to allow the educators to give valuable feedback on suggestions for improvement of the handbook. The evaluation examined the educators' knowledge and understanding of conduct disorder and strategies for students displaying conduct problems based on reviewing *Conduct Disorder: A Handbook for Elementary School Educators*. The educators received an evaluation package on October 2<sup>nd</sup>, 2014. The evaluation package included a cover letter, a copy of the questionnaire to be completed, and a copy of the Conduct Disorder handbook. The cover letter described the rationale for the research project along with instructions on completing and returning the necessary documents. The educators were given a time frame of October 6<sup>th</sup>, 2014 to complete the questionnaire. The completed questionnaire was sealed in a confidential envelope with the participant's number on it and left with the educators' administrative assistant to be picked

Table 3

*Participants of Evaluation Questionnaire*

Participant	Gender	Current Grade(s) of Instruction	Years of Teaching Experience
1	Female	Kindergarten	2 years
2	Female	7 and 8	6 years
3	Male	3 and 4	10 years



up by the researcher.

### *Conclusions from the Evaluation*

The findings of the evaluative questionnaire were aggregated by question. Below is a summary of the findings. Again, space was provided so the educators could provide additional feedback. The feedback section was optional and not a requirement.

#### Question #1

Please read the Introduction section for *Conduct Disorder: A Handbook for Educators*

- a) Does the Introduction outline the importance and necessity for the creation of the handbook in a mainstream classroom setting? Yes/ No
- b) Does the Introduction clearly outline the structure and organization of the handbook? Yes/ No
- c) Does the Introduction clearly outline the objectives of the handbook? Yes/ No

All three participants replied 'yes' to each part of Question #1. Participant #1 and #2 provided additional feedback on the Introduction section of the handbook. Participant #1 stated that CD is not a term commonly used in school and that teachers need to be educated on this disorder. Participant #2 confirmed that early intervention is crucial in providing affected students with the help needed. Participant #1 and #2 commented that the handbook was well organized.

#### Question #2

Please read the section of the handbook- *What is Conduct Disorder?*

- a) Does Section One clearly define conduct disorder? Yes/ No
- b) Does it outline the forms of conduct disorder? Yes/ No

c) Do you have a better understanding of conduct disorder after reading this section?

Yes/ No

Participant #1 and #3 answered 'yes' to each part of Question #2. Participant #2 answered 'no' to question 2a and stated that they would have preferred more detail on how CD is different from ODD. Participant #1 liked how information was presented in tables and commented that this would be useful for teachers to use as a quick reference.

Participant #2 was unaware of the different forms and subtypes of CD and stated the importance of judging conduct problems with reference to the students' age.

### Question #3

Please read the section of the handbook- Types of Treatments and Interventions of Conduct Disorder

a) Do you have a better understanding of how to clearly classify the types of treatments and interventions for conduct disorder having read this? Yes/ No

b) Does it provide clear and adequate descriptions of the types of treatments available? Yes/ No

All three participants answered 'yes' to each question. Participant #1 and #3 made additional comments pertaining to the organization of the information. Participant #1 liked that the information was organized in a chart because “it allows you to access the important information quickly”. Participant #3 commented on the layout of the table and “liked how it was broken down under different headings. The feedback from the participants was reassuring because they all found the chart helpful and educators may be more likely to utilize the handbook if they feel the information is easily accessible.

Question #4

Please read the section of the handbook- *Conduct Disorder in the Classroom: What can you do?*

- a) Is the section on the acting out cycle and how to approach a student who displays signs of conduct disorder beneficial? Yes/ No
- b) Do the support strategies effectively address the concern of what educators can do to better understand and help aggressive students? Yes/ No
- c) Would you utilize any of the strategies and tips with students with conduct problems in your classroom? Yes/ No

All three participants answered 'yes' to each part of Question #4 and chose to make additional comments on this section of the handbook. Participant #1 thought the figure of the acting-out cycle was beneficial but suggested that it be displayed on a two-page spread. Participant # 2 and #3 liked how the suggested strategies included in the handbook seemed easy to implement. All of the participants commented that they believed the strategies and tips would be useful for all students in their classrooms, not just those with diagnosed with CD.

Question #5

Please review the section on *A Six Session Intervention Plan for Conduct Problems in the Mainstream Classroom*

- a) Are the facilitator notes clear and easy to follow? Yes/ No
- b) Would you try to use these lessons with the students in your classroom? Yes/ No

Again, all of the participants selected 'yes' to both parts of Question #5. Participant

#2 and #3 chose to provide additional feedback. Participant #2 stated that she liked how the handbook provided an overview of the six sessions for educators to follow. Participant #2 liked how the lessons were divided by skill (i.e., Anger Management/ Thinking Error Correction, Social Skills, Social Decision Making) because educators “can refer back to a lesson based on the skills the student needs to work on”. Participant #3 spoke about the value of the facilitator notes, especially for the Social Decision Making lessons. Participant #3 did not think that the lessons would be appropriate for all elementary school students, but believed that they could be altered for each individual. I agree with Participant #3 and suggest within the facilitator notes that educators alter the problem situations for more mainstream student groups.

#### Question #6

Please read the section on *Resources and Programs Available for Conduct Disorder*

- a) Is the list of community resources or agencies practical and applicable? Yes/ No
- b) Is the list of available resources practical and applicable? Yes/ No

All of the participants selected 'yes' to both parts of questions #6 and commented on how they were surprised at the number of community resources available for students with CD. Participant #1 stated, “the list would be useful for parents of children with conduct problems”. Participant #3 commented on the organization of the list and liked that the list included ages and languages, and area served. The resource section of the handbook contained enough information so educators can become better informed of the available services for students displaying conduct problems.

### Question #7

Are other comments that you would like to share concerning conduct disorder and *Conduct Disorder: A Handbook for Educators* (e.g., organization, easy to use and understand, relevance, and conciseness) would be greatly appreciated.

All of the participants mentioned that the handbook was “informative and practical”. Participant #1 and #3 recommended that the handbook be shared with administration, guidance counsellors, and social workers at the school. Participant # 2 said that the handbook was a valuable tool for educators and wanted to share the resource with other colleagues in the elementary panel.

The feedback from the evaluation questionnaire suggests that the handbook is a informational, practical, and applicable resource for elementary school educators in mainstream classrooms. No major revisions were needed or recommended for the handbook.

### **Implications for Practice**

The handbook- *Conduct Disorder: A Handbook for Elementary School Educators*, was written with a focus on elementary school educators and has practical value for educators in mainstream classrooms. The handbook provides educators with information on CD, strategies, and activities to try. Additionally, educators are provided with a list of resources and community agencies that can be access when needed. The evaluation of the handbook suggests that the participants learned about CD from reading the handbook.

Both the needs assessment and the positive feedback from the evaluation questionnaire suggests there was a need for an informative resource on CD. This is

probably due to the lack of educator knowledge on the disorder and the prevalence and severity of CD among students in mainstream classrooms. Equipped with a better understanding of CD, educators can modify the activities of the handbook and integrate them into the curriculum.

This project has emphasized the need for educators to have an understanding of CD and to be able to implement the appropriate strategies and activities necessary to prevent or lessen antisocial and aggressive behaviours (Austin & Sciarra, 2010; Kauffman & Landrum, 2013). While *Conduct Disorder- A Handbook for Elementary School Educators*, is a good starting basis for educators, it is recommended that educators individualizes the strategies and activities for the students in their classrooms.

### **Implications for Theory**

There is a theoretical implication of this project. According to Bandura (1978), aggression is learned through direct consequences of aggressive and nonaggressive acts and through observation of aggression and its consequences. However, consequences of behaviour can be influenced by stereotypes of race, ethnicity, diagnostic label, and socioeconomic status (Phillips & Lonigan, 2010). Stereotypes play a role in the differential expectations and comparisons teachers have for different students (Phillips & Lonigan, 2010). In addition, the teachers' interpretations of behaviours influence attribution formation and discipline (Lovejoy, 1996). Undercontrolled behaviour is associated with internal causes and is believed to be controlled by the child. This attribution is related to teachers' affective and disciplinary reactions to student behaviour (Lovejoy, 1996). A teachers interactions and attitudes towards a child can positively or negatively shape the

development and maintenance of externalizing behaviour. To fully understand the developmental trajectory of children's behaviour it is necessary to consider the role of observer.

### **Limitations of the Project**

*Conduct Disorder: A Handbook for Elementary School Educators* is a practical resource that provides educators with hands on activities and strategies that can be utilized in mainstream classrooms with students affected by CD. There is a wealth of literature on aggression and CD among children and youth, but the handbook offered a condensed version of the literature on child-onset and adolescent-onset CD. Within the scope of this research, it was necessary to conduct an applicable and effective dissemination of the background information of CD and suggested strategies for educators.

The handbook was developed due to the prevalence and severity of CD, as well as the findings on the needs assessment. Due to the limitation of time, the needs assessment was limited to three participants. Including more participants would have offered a greater representation of the needs of educators with regards to CD and how to improve the academic experience for students who have CD.

Lastly, the participants involved in the project did not have the time to implement the strategies or activities in their classes. If the participants would have utilized the handbook prior to completing the evaluative questionnaire, their opinions or feedback might have been different. Instead, their responses were based on their previous educational experiences.

### **Recommendations for Further Research**

Antisocial behaviour needs to be addressed at all levels of prevention (i.e., primary, secondary, and tertiary). While elementary school educators were utilized in the development of this handbook, it would be beneficial to also incorporate secondary school teachers since adolescent-type onset develops after the age of 10. By including both elementary and secondary educators, the handbook could have better addressed all of the levels of prevention. Since CD needs to be judged with reference to chronological age, it would be interesting to investigate the differences between elementary and secondary educators' knowledge of, and experiences with, the disorder.

Furthermore, ODD, ADHD, and CD are closely linked. This handbook focused on strategies and activities to prevent or lessen behaviours associated with CD. Still, most of the strategies could conceivably be adapted for students who exhibit anxiety and depression. For researchers creating handbooks as a resource for elementary school educators of antisocial and aggressive students, it is recommended that prevention is proactive and instructive. Teachers need to ask what prosocial skills the student needs to learn as a replacement for aggression.

Lastly, the feedback from the needs assessment demonstrates that educators' knowledge of CD is limited. A resource guide on antisocial and aggressive behaviours in children and youth may be useful for elementary school educators.

### **Summary of the Chapter**

The feedback received by the participants regarding the handbook was valuable and informative. For Question #1, the participants were asked to read the introduction of the



handbook and determine how effective it was. All of the educators found the introduction to be reader friendly. The additional commented provided acknowledged the importance of early intervention and the need for an educators resource focused on CD.

Question #2 asked if the definition of CD was adequate and helped them to have a better understanding of the disorder. All of the participants reported having a better understanding of CD after reading the section. However, one participant stated that there should have been more detail provided to distinguish CD from ODD. Another participant commented on the learning that occurred for them surrounding the different forms of CD. A handbook on CD is necessary for elementary school educators to be able to identify and classify antisocial and aggressive behaviour.

There are various interventions and treatments for CD and aggression. In Question #3, educators indicated that they gained a better understanding of the types of treatments and interventions of CD. The table provided made the information easily accessible to the participants. Such feedback is important because educators may be more likely to refer back to the handbook if the information is well organized and accessible.

The next question focused on the second part of the handbook. Question #4 asked educators to review the acting-out cycle and strategies provided in the section “What Can you do”. All of the participants agreed that the information was beneficial and that the strategies were applicable in the mainstream classroom with students affected by CD. One educator suggested displaying the figure of the acting-out cycle across two pages. I decided not to break up the diagram because the build-up of the information might be lost. Overall, the educators seemed pleased with the strategies and activities provided.

Question #5 focused on the Six Session Intervention Plan for Conduct Problems in the Mainstream Classroom. Educators found the facilitator notes easy to follow and agreed that the activities could be utilized in their classrooms. One of the educators commented on the appropriateness of the problem situations in the Social Decision Making lessons but mentioned that they could be altered for more mainstream student groups. I recognize the educator's concern and included a precautionary note in the facilitator notes pertaining to it.

Resources and programs available for CD was the focus of Question #6. Educators were asked to look at the list and determine if it was practical and applicable. The participants provided positive feedback about the organization and details of the list. Participants expressed their surprise at the number of community resources available for students with conduct problems. One of the participants mentioned that the list would not only be useful for educators, but for parents of children with CD too.

The final question asked educators to share any other comments they had concerning their overall impression of the handbook. Some of the responses included: an informative and practical resource, can be shared with other colleagues, and a valuable tool for elementary school educators. The positive feedback received from Question #7 was appreciated. It is my hope that the handbook will be used by elementary school educators in mainstream classrooms to improve the school experience of children and youth affected by CD.

Recognizing the large prevalence of CD and its adverse outcomes, the considerable stability of the diagnosis overtime, and the risk of escalating aggressive and

antisocial behaviour in untreated patients, it is important for educators to be able to predict predict antisocial behaviour in order to be able to prevent it (Ercan et al., 2011). Educators Educators should be equipped with strategies and interventions that they feel confident to use to address the academic and behavioural concerns for children and youth diagnosed with CD.

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## Appendix A

### *Conduct Disorder: A Handbook for Elementary School Educators*

#### Information and Informed Consent

Date: August 11, 2014

Project Title: *Conduct Disorder (CD): A Handbook for Educators*

Principal Investigator (PI): Dr. Ann-Marie DiBiase

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Student Principal Investigator (SPI): Presley Chiasson, Med Student

**Department of Education**

Brock University

[pc08to@brocku.ca](mailto:pc08to@brocku.ca)

I, Dr. Ann-Marie DiBiase and Presley Chiasson, from the Department of Education, Brock University, invite you to participate in a research project entitled *Conduct Disorder (CD): A Handbook for Elementary School Educators*.

The purpose of this project is to develop an informative and practical resource for teachers in the form of a handbook outlining research-based strategies and techniques that can be used when working with students with CD. This invitation has been extended to three to five other educators, who have been identified by their principal, based on their experience working with children with externalizing disorders.

#### WHAT'S INVOLVED

I am developing a handbook for secondary school teachers to use for adolescents with CD in mainstream classrooms. To assist me in this work, I am asking you to participate in two tasks:

- First, please complete the needs assessment enclosed.

The assessment is a semi-structured questionnaire that consists of seven short answer questions and one question using a rating scale. The needs assessment will allow me to collect data from educators to determine their knowledge and understanding of CD, which will influence the information I will provide in the handbook.

I have also enclosed an envelope that has been coded with a randomly assigned number. . Please keep a record of this number as you will receive a second package that corresponds

to it. When you have completed the needs assessment, place it in the coded envelope, seal it, and return it to your administrative assistant. I will collect the envelopes from the administrative assistant.

- Next, in approximately two weeks, I will forward a draft copy of the handbook for your review. Enclosed will also be an evaluative questionnaire for you to complete.

These will come with an envelope marked with your code number. . The questionnaire evaluates the significance, usefulness, simplicity, and aesthetics of the handbook. If you agree to participate, please follow the same procedure and leave your completed questionnaire in a sealed envelope with the administrative assistant.

Participation will take approximately 1.5 hours of your time (30 minutes or less to complete each of the the Needs Assessment and the Evaluative Questionnaire and another 30 minutes to review the draft handbook).

An executive summary of my study will be left at your school for you once all data collection and analysis has been completed..

### **POTENTIAL BENEFITS AND RISKS**

The needs assessment allows educators to identify and verbalize what they would like to see in the handbook. The evaluation will further allow you to assess whether your needs have been addressed in the handbook, and to decide whether you would use the handbook in a mainstream classroom with students with CD. There are no known or anticipated risks associated with participation in this study.

### **CONFIDENTIALITY**

All information provided by you is considered confidential. Only aggregate (average) scores will be presented in any verbal or written reporting of the study. That is *neither* your name, school name, nor the names of any school staff will appear in any verbal or written reporting of this study. Participant's gender, years of teaching experience and teaching grades will be included in the report.

In order to further protect your confidentiality, we will have no direct interaction; materials will be delivered and collected in coded and sealed envelopes, via your school's administrative assistant. School personnel will not have access to the individual responses of any of the participants in this study.

Data collected during this study will be stored in a secure location within the Faculty Supervisors office. It will be entered into databases on the researcher's password protected computer using numerical codes. All paper and electronic data will be held for six months, after which it will be shredded / deleted / destroyed.

Access to this data will be restricted to the PI, Dr. Ann-Marie DiBiase, and the SPI, Presley Chiasson.

**VOLUNTARY PARTICIPATION**

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. This is a Master's student project; the decision on your part to participate or not will have no impact on your employment or standing within the school/school board. Further, you may decide to withdraw from this study at any time and may do so without any penalty. At the point of your withdrawal no further data will be collected.

If you wish to withdraw from the study at any time, please contact the researchers with your participant number. All of your data will be destroyed confidentially.

**PUBLICATION OF RESULTS**

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available in the fall of 2014. Please contact Presley Chiasson by email at [pc08to@brocku.ca](mailto:pc08to@brocku.ca). Participants will receive an Executive Summary of the study's findings once data analysis has been completed.

**CONTACT INFORMATION AND ETHICS CLEARANCE**

If you have any questions about this study or require further information, please contact Dr. Ann-Marie DiBiase or Presley Chiasson using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [14-037-DIBIASE]. If you have any comments or concerns about your rights as a research participant, please contact the Brock University Research Ethics Office at (905) 688-5550 Ext. 3035, mail to: [reb@brocku.ca](mailto:reb@brocku.ca).

Thank you for your assistance in this project. Please keep a copy of this form for your records.

Your consent is implied through the submission of this questionnaire.

### Needs Assessment Questionnaire

Participant No.

Date:

Current Grade(s) of Instruction:

Years of Teaching Experience:

**1. Please circle the number which most accurately describes your position on the following statements:**

	Strongly Disagree	Disagree	I do not know	Agree	Strongly Agree
I have extensive knowledge of conduct disorder.	1	2	3	4	5
I am familiar with the criteria used to diagnose students with conduct disorder.	1	2	3	4	5
I am aware of different interventions for students with conduct disorder.	1	2	3	4	5
I feel adequately prepared to teach students with conduct disorder in a mainstream classroom.	1	2	3	4	5

**2. How would you define and describe conduct disorder?**

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**3. What are some of the specific behaviours that students with conduct disorder exhibit that effect learning in a classroom context?**

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**4. What are some of the challenges when teaching students with conduct disorder?**

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**5. Please identify any treatments or intervention programs that you are aware of for adolescents with conduct disorder.**

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**6. What are some strategies or programs that you have utilized in your classrooms with children and youth with conduct disorder? Do you utilize the same strategies for students who display similar behaviour patterns, but have not been diagnosed with conduct disorder?**

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**7. What are some of the elements that you feel would make a handbook for teaching students with conduct disorder effective for educators? Please consider types of strategies and information that would be most beneficial to you.**

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**8. Are there any other comments or suggestions that you may have regarding conduct disorder and a handbook for teaching students with conduct disorder?**

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**9. How did you feel when completing this questionnaire?**

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## **Appendix B**

### **Evaluation Questionnaire**

#### *Conduct Disorder: A Handbook for Elementary School Educators*

An operative method of determining the reasonableness and effectiveness of the *Conduct Disorder: A Handbook for Elementary School Educators* is to obtain direct feedback from the educators who may utilize the handbook. The handbook was produced by the researcher as one of the requirements for her Masters of Education Project.

The evaluation package contains a copy of the conduct disorder handbook and the evaluation questionnaire. The purpose of the evaluation questionnaire is to determine how valuable the handbook is for educators working with students with conduct problems in mainstream classrooms. Educators are asked to review and assess the conduct disorder handbook. The responses from the evaluation will provide the research with the necessary opinion concerning the usefulness of the *Conduct Disorder: A Handbook for Educators* to:

- 1) Assist educators in developing a better understanding of conduct disorder
- 2) Provide educators with strategies and skills to help students deal with anger and aggression
- 3) Provide educators with a list of resources and agencies that can be shared with both parents and students

The questionnaire also assesses the researcher's ability to meet the articulated needs of educators regarding a resource guide.

Please note that all replies are unidentified and confidential. You should not indicate your name on the questionnaire. A randomly assigned participant number will be assigned



to all participants. You will only be acknowledged by this participant number.

Your time and effort in completing this questionnaire is much appreciated. Please leave the completed questionnaires with your administrative assistant in the envelopes provided by (insert date).

Should you have any questions or concerns, please feel free to contact me via email  
pc08to@brocku.ca

Thank you for your time,

Presley Chiasson

### Evaluation Questionnaire

Participant No.

Date:

Gender:

Current Grade(s) of Instruction:

Years of Teaching Experience:

**1. Please read the Introduction section for *Conduct Disorder: A Handbook for Educators***

- a) Does the Introduction outline the importance and necessity for the creation of the handbook in a mainstream classroom setting? Yes/ No
- b) Does the Introduction clearly outline the structure and organization of the handbook? Yes/ No
- c) Does the Introduction clearly outline the objectives of the handbook? Yes/ No

Additional Comments:

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**2. Please read the section of the handbook- *What is Conduct Disorder?***

- a) Does Section One clearly define conduct disorder? Yes/ No
- b) Does it outline the forms of conduct disorder? Yes/ No
- c) Do you have a better understanding of conduct disorder after reading this section?

Yes/ No

Additional Comments:

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**3. Please read the section of the handbook- *Types of Treatments and Interventions of Conduct Disorder***

- a) Do you have a better understanding of how to clearly classify the types of treatments and interventions for conduct disorder having read this? Yes/ No
- b) Does it provide clear and adequate descriptions of the types of treatments available?

Yes/ No

Additional Comments:

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**4. Please read the section of the handbook- *Conduct Disorder in the Classroom: What can you do?***

- a) Is the section on the acting out cycle and how to approach a student who displays signs of conduct disorder beneficial? Yes/ No
- b) Do the support strategies effectively address the concern of what educators can do to better understand and help aggressive students? Yes/ No
- c) Would you utilize any of the strategies and tips with students with conduct problems in your classroom? Yes/ No

Additional Comments:

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**5. Please review the section on *A Six Session Intervention Plan for Conduct Problems in the Mainstream Classroom***

- a) Are the facilitator notes clear and easy to follow? Yes/ No
- b) Would you try to use these lessons with the students in your classroom? Yes/ No

Additional Comments:

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**6. Please read the section on *Resources and Programs Available for Conduct Disorder***

- a) Is the list of community resources or agencies practical and applicable? Yes/ No
- b) Is the list of available resources practical and applicable? Yes/ No

Additional Comments:

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**7. Are other comments that you would like to share concerning conduct disorder and *Conduct Disorder: A Handbook for Educators* (e.g., organization, easy to use and understand, relevance, and conciseness) would be greatly appreciated.**

Comments:

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